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MALE-TO-FEMALE TRANSSEXUAL INDIVIDUALS' EXPERIENCE OF  
CLINICAL RELATIONSHIPS: A PHENOMOLOGICAL STUDY

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A Dissertation

Presented to

The Faculty of the Graduate School of Social Work

University of Denver

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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by

Karen M. Scarpella

August 2010

Advisor: Susan Manning, Ph.D.

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Title: MALE-TO-FEMALE TRANSSEXUAL INDIVIDUALS' EXPERIENCE OF  
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Advisor: Susan Manning, Ph.D.

Degree Date: August 2010

### **Abstract**

This phenomenological study was designed to gain insight into male-to-female transsexual clients' experience of clinical relationships. Transsexual clients who enter into a clinical relationship have an experience that is unique due to their transsexual status in society. Their circumstances warrant attention in research due to the following factors: 1) the nature of being transsexual 2) the gate-keeping requirements necessary for transition 3) their experience in society as a vulnerable and oppressed population, and, 4) the importance of understanding the transsexual individuals' experience of clinical relationships from the perspective of transsexual clients themselves. Twelve transsexual women were interviewed using semi-structured format utilizing open-ended questions regarding their experiences. Participants ranged in age from 30 to 64, and their year's post-SRS/GRS ranged from 20 months to 33 years. The data was analyzed using Moustakas' modified version of the Van Kaam method of analysis. The findings were grouped into four core themes: What the client brings to the clinical relationship, what the therapist brings to the clinical relationship, the experience of the clinical relationship, and the outcome of the clinical relationship. The essence of the experience is stated as fear driven self-preservation. It was found that participants feared rejection and expressed self-preservation initially by suppressing their transgender identity. After experiencing a crisis and/or catalyst, the participants changed their self-preservation focus to gender role transition, at any cost. The combination of this self-preservation for transition, and fear of clinicians' power in the gate-keeping process provided

challenges for therapeutic alliance and trust in the clinical relationship. Participants expressed a change of attitude towards therapy, therapists, and the standards of care post-transition. Implications for social work research, theory, practice and education are discussed.

## **Acknowledgements**

I have always felt that higher education is about opportunity and desire. I am now clear that it is also about understanding that success in higher education is not a solo venture, that we accomplish our goals with the assistance and support of many people. As a disabled woman, I could not have reached this life-time achievement without the help of many people, some of whom I would like to mention here.

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## **Chapter 1**

This research is a phenomenological study to gain insight into the experience of male-to-female transsexual individuals who enter into a clinical relationship initiated by their transgender status and for other clinical reasons. In order to better inform clinicians of client concerns, the focus of this study is to better understand the clinical experience from the perspective of those who go through it.

Twelve participants were interviewed, and interview data were analyzed via manual coding using Moustakas' (1994) modified version of the Van Kaam method of analysis. The findings are presented in Chapter 4 and the implications and recommendations are discussed in the final chapter. The theoretical framework of this work is guided by the principles of symbolic interactionism (Blumer, 1969), labeling theory (Becker, 1963), and Lev's (2004) transgender emergence developmental stages model.

### **Definition of Key Terms**

The terms and language for the gender community are complicated and fraught with identity politics. This section will briefly define and provide explanation for term choices in this dissertation. For detailed glossary and contextual definitions, see glossary by Kelley Winters in appendix A.

For the purpose of this study, individuals in the population under consideration are those who meet the Diagnostic and Statistical Manual (DSM) criteria for gender identity disorder, and *do* seek medical intervention to alter their sex/gender presentation to be congruent with their gender identity, referred to in this dissertation as transsexual individual. Most people who have this identity refer to themselves as "transsexual," but a

key informant requested that transsexual not be used as a noun. For this reason, although awkward/unfamiliar, the term transsexual individual will be used in this dissertation. The term transgender is sometimes used synonymously with transsexual, but most often used as an umbrella term to be inclusive of all forms of gender-variance. When referring to the sample in this study, or the segment of the transgender population that transitions gender roles, the term transsexual individual will be used. The term transgender will be used when using a citation, or when referring to the larger gender variant community.

Surgical correction of genitals for transsexual individuals was originally referred to in lay terms as “sex change” or a “sex change operation,” but during the past several decades the term used has been sex reassignment surgery (SRS) (Brown & Rounsley, 1996). Contemporary identity politics have introduced many new variations, preferred terms and acronyms, such as sex reconstruction surgery (SRS), gender reassignment surgery, genital reassignment surgery, or genital reconstruction surgery (GRS). A contemporary term currently gaining some acceptance is gender confirming surgery (GCS). The medical terms rarely used by non-medical persons are feminizing genitoplasty and masculinizing genitoplasty (Martin & Yonkin, 2006). Gender advocates, writers, and scholars all use these different terms, but the one most prevalent in the literature, as stated above, is sex reassignment surgery (SRS). For simplicity and consistency in this paper, the term SRS will be used to identify surgical genital alteration, recognizing that some may disagree with the terminology. SRS is sometimes used as an umbrella term to be inclusive of breast augmentation, orchiectomy and breast reduction (Ettner, 1999). Because legal definitions of sex are most often determined by genital

configuration (Bell, 2004; Bernstein, 2005), SRS in this paper will only refer to genital alteration. The term "post-op" refers to time post operative from SRS.

The standards of care refer to the guidelines set for transgender care, particularly those who request hormonal and surgical interventions. Part of the standards of care recommend that transsexuals live in their target gender for a period of time before having hormones and/or surgery. This time period is called the "Real Life Experience" or RLE, also formerly known as the real life test.

The term "clinical" refers to social work with individual clients who have personal challenges both in their personal functioning and in their social systems. In a broader spectrum of helping professions, clinical can refer solely to psychotherapy. However, the social work profession relies on generalist and ecosystems approaches; thus, clinical work with individuals can consist of case management, brokering of services, as well as psychotherapy, and other therapeutic approaches as needed (Compton, Galaway & Cournoyer, 2005). Transgender clients frequently need a diverse range of services and assistance from a social worker. Therapeutic approaches and models are needed on occasion to resolve inner conflict and confusion, or trauma caused by oppression, suppression, social ostracism and interpersonal loss due to gender role transition. The broader social work perspective on the use of the term "clinical" is being used in this research.

### **Statement of the Problem**

Transsexual clients who enter into a clinical relationship have an experience that is unique due to their transsexual status in society. Their circumstances warrant attention in research due to the following factors: 1) the nature of being transsexual 2) the gate-

keeping requirements necessary for transition 3) their experience in society as a vulnerable and oppressed population, and, 4) the importance of understanding the transsexual individuals' experience of clinical relationships from the perspective of transsexual clients themselves.

### **The Nature of Being Transsexual.**

People who experience a conflict between their assigned sex and their gender identity are most often defined as transsexual. Transsexual as an identity is unique in that this birth variance has been defined as pathological. The recommended treatment for this birth variance is gender role transition, often including hormonal and genital reconstruction to align body and mind. This condition is identified as a mental health issue, yet the treatment is alteration of the body with medical intervention. To obtain these medical treatments, transsexual individuals must be labeled as mentally ill per criteria listed in the Diagnostic and Statistical Manual (DSM).

### **Gate-keeping Requirements for Transition.**

Transsexual individuals who request medical treatments such as hormone or body modification through surgery are required to obtain a letter of referral from a mental healthcare professional. This requirement was created by medical professionals who developed a standard of care for medical interventions. These guidelines are called the standards of care (SOC) (refer to appendix B). The organization developed to advance clinical expertise and later inform these standards was called the Harry Benjamin International Gender Dysphoria Association (HBIGDA), now named The World Professional Association for Transgender Health, Inc. (WPATH). A detailed component of the standards is psychological assessment recommended for specific periods of time

before obtaining medical treatment. This is deemed by many professionals and transsexual individuals as *gate-keeping* by the medical and psychotherapeutic professions (Hird, 2002; Martin & Yonkin, 2006; Wilson, 1998).

Gate-keeping in this context refers to the SOC guidelines that are interpreted by the gender variant population to mean that mental health professionals are in the position of deciding who can or cannot receive transgender specific body modification. Activists continually state the argument that other forms of plastic surgery do not require such approval for the procedure, so neither should Sex Reassignment Surgery (SRS) (Namaste, 2005). Lev (2009) counters with the argument that some body modifications and other medical procedures do require an assessment from a mental health professional before undertaking, such as gastro-bypass surgery and fertility treatment. She continues with the assertion that assessment or evaluation of this sort is appropriate and within the scope of mental health. However, she has also recognized the negative role of gatekeeping, and has spoken out about the need to reform assessment processes (2009). This assessment prior to medical procedures also protects surgeons who may not be able to determine if a person understands the informed consent process for irreversible surgery (Lev, 2009).

Historically, some clinicians and physicians made judgments regarding a person's appropriateness for treatment based on their perception of the given person's potential to assimilate into mainstream society. This meant that patients who did not claim to be homosexual (heterosexual after surgery) were denied permission to proceed with medical interventions. Another problematic determinate of medical intervention is the capacity of

the transsexual individual to pass as fully female in appearance after surgery (Meyerowitz, 2002).

Standards-of-care (SOC) guidelines have been developed and revised five times since their inception, and currently are under further revision. Even though each subsequent revision progressed to a more contemporary understanding of need and social bias, the history of denying those who stated they needed surgery based on gatekeeper's sexist and heterosexist perspectives has caused generational trauma for many transsexual individuals. Historical accounts continue to be recounted throughout many parts of the transgender community, causing understandable fear and distrust of the clinical and medical communities (Martin & Yonkin, 2006).

### **Transsexual Individuals as a Vulnerable Population.**

Transsexual individuals are a vulnerable population who face chronic experiences of improper media portrayals of transsexual identity (Gamson, 1998). Many have been harassed on the streets by strangers (Moran & Sharpe, 2002; Valentine, 2003). Lombardi, Wilchins, Priesing, and Malouf (2001) reported that 60% of transsexual individuals have been victims of hate crimes, including assault with a weapon and/or sexual assault. Also in this study, 37% of respondents reported discrimination resulting in financial loss, primarily due to job loss associated with non-conforming gender presentation. There are many reports of brutal murders of transsexual individuals, but there is speculation that many murder investigations are mishandled or go unreported (Korell & Lorah, 2007). There is an annual Transgender Day of Remembrance each November when the names of that year's transgender victims of hate crimes is read during ceremonies in cities all over the world.



In addition, many more transsexual individuals are traumatized by degradation through loss of family connections, child visitation rights, and invalidations of marriages (Green, 2006). These losses and social oppression render many transsexual individuals vulnerable and hopeless. Lack of proper understanding of the process and informed support causes many to live in complete distrust of sharing their true gender identity. This distrust has extended into the clinical realm due to the history of rejection by medical professionals.

### **The Importance of Understanding Transsexual Clients' Perspectives.**

This research is directed towards capturing transsexual individuals' experience of clinical relationships from the perspective of transsexual individuals who have gone through the process. Because this population has been pathologized, marginalized, and stigmatized, it is imperative that understanding of this phenomenon come from the voice of transsexual clients. Research conducted about a marginalized population without directly involving them in the research process can perpetuate misconceptions based on bias and privilege.

### **Background of the Problem**

There is a general confusion and lack of understanding regarding gender variance and transsexual identity. This is an emerging identity category that requires further study and clarification. Gender variance spans a broad range of identities and expressions, but transsexualism is a gender identity in which the mind and body dysphoria are intense enough to require body modification. Although varied gender expressions have existed throughout history, with recent medical advances clearer definitions have emerged.

Magnus Hirschfeld created the term “transsexualism” in 1869, and worked with several physicians who began to differentiate gender identity from sexual orientation.

When no medical options existed, many transsexual individuals blended into other gender categories, including sexual orientation minorities (Feinberg, 1996; Meyerowitz, 2002). Current understanding of transgender identities and transsexualism has changed over the years. Until recently, much of western cultural history considered homosexuals as a third gender in which men who were attracted to men were actually women, and women who were attracted to women were in fact, men (Calafia, 1997). In other cultures and times young boys were taken as lovers by older men, to show them the ways of love. After the boys matured, they married and lived heterosexual lives (Feinberg, 1996).

Katz (1995) reported that the concept of homosexuality and heterosexuality was created naming heterosexuality as normal, so homosexuality could be delineated as opposite of social sexual norms. Kailey (2003) mused that by dividing and labeling natural variations of sexual behavior, individuals were able to remove themselves from the uncomfortable topic of sexuality. With each additional simplification and value laden category such as “straight, gay and lesbian, and bi,” people feel more confident that they know who is normal and who is not. Kailey went on to say that establishing labels for people keeps the dominant culture in control and identifies who should be punished for acting outside established norms.

The challenge then becomes one of identifying and labeling who is male and who is female. If homosexual sex is defined as sexual acts between two males or two females, it is important to know if one is a male or female. This clarification is superficially simple, generally signified by the configuration of one’s genitals. Another positive identifier is the XX or XY chromosomal indicator. Socially, the masculine or feminine gender presentation is the criterion for assessing one as male or female. This all seems

clear considering the many varied versions of sex, orientation, and gender identity, which are thrown into the mix (Kailey, 2003).

For many years “transvestism” and transsexual individualism were considered a sub-category of homosexual identity (Hekma, 1994; Katz, 1995). The term "invert" was used to define homosexuals who wanted to change sex to comply with heterosexual standards. Those who cross-dressed and engaged in gay sex were perceived to be acting as the other sex. People who had gay sex and did not violate gender norms were called perverts, people who were actually not gay but had been seduced by legitimate homosexuals (Feinberg, 1996). Given this confusing understanding of homosexuality and gender identity/role, it is understandable that retrieving accurate accounts of sexual orientation and gender identity in the literature is very complicated. It is unclear who was gay and who was truly transsexual individual or transgender (Lev, 1998).

Through access to the Internet and other sources of information the gender identity of transsexual individuals became delineated from that of a gay identity to that of an individual who desired to alter his body for the reason of resolving the mind/body incongruence. Thus, the search for medical advancements ensued. Reports of surgical techniques for various medical issues became the catalyst for transsexual individuals to seek out doctors who could reshape their bodies through hormonal and surgical intervention (Lev, 2004).

Present day genital reconstruction began in 1940s (Lev, 2004). It was the public reports of Christine Jorgensen's sex reassignment surgery that made known the possibility of surgical sex reassignment. At that time, there was an onslaught of requests for genital surgery. It was Harry Benjamin, MD, who realized that it may not be wise for surgeons to

perform this permanent body modification without some guidelines to determine criteria for surgery (Bullough & Bullough, 1993). WPATH (then HBGDA) decided that patients who wish to receive body modification medical treatment for gender role transition should be evaluated for appropriateness for these procedures. Standards of care were developed to help clinicians evaluate patients for recommendation.

An individual's identity is developed based on the available choices known to them. Upon clarifying the concepts of sexual orientation, sexual norms and social standards, the issue of differentiating gender identity was more viable (Feinberg, 1998). Describing homosexual identity became possible once the concept was named and delineated from heterosexuality. Given a clearer understanding of sexual identity, it was then possible to consider gender identity as separate from sexual orientation (Devor, 2002).

Although epidemiology studies have varied results given the hidden nature and stigma associated with gender dysphoria, it is estimated that as many as one in 500 individuals have this condition (Conway, 2001). For most male-to-female transsexual individuals, the only known resolution of gender dysphoria is body modification through hormone therapy and genital reconstruction (Meyerowitz, 2002). Due to a history of patients with regret after surgery, a standardized policy was developed by World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA.) WPATH recommends appropriate screening of sex reassignment surgical (SRS) applicants to reduce the number of patients who might have regret about having the procedure after it is completed. Although there are low numbers of transsexual individuals who report

regret after SRS (Pfafflin, 2007), it is important to reduce the number further through assessment and evaluation and informed consent before proceeding with the surgery. The surgery is irreversible, and if an individual regrets having undergone the procedure, it can be emotionally and socially devastating, sometimes even leading to suicide (Olsson & Moller, 2006).

### **Prevalence**

Although the modern western perception is that transsexualism is a recent social phenomenon, transgender expression and experience is documented as having existed throughout history (Devor, 1997; Feinberg, 1996; Green, 1998). Epidemiology studies and reporting for transsexualism is extensively skewed based on blended identity groups, lack of access for researchers due to oppressed/closeted transsexual individuals, and confusing and conflicting clinical criteria (Tobin, 2003). At the time of print in 2000, the Diagnostic Statistical Manual (DSMIV TR) estimated that one in 30,000 biological adult males and one in 100,000 biological adult females met the criteria for Gender Identity Disorder, also known as transsexualism (APA, 2000). The current (6<sup>th</sup>) version of the Harry Benjamin Standards, published in 2001, estimates one in 11,900 males and one in 30,400 females are transsexual individuals (HBIGDA, 2001). Both these texts are currently in revision (Lev, 2009) and have the potential of updating these numbers. Conway (2001) challenged the prevalence estimates of the male-to-female (MtF) transgender experience in the U.S. She concluded that from one in 500 to one in 2,500 individuals were incorrectly assigned a male gender at birth is closer to the actual rate in the population. Conway described her analysis of the prevalence of MtF transsexualism as follows:

We first estimate the number of post-op women in the U.S. by accumulating the estimated numbers of sex reassignment surgeries (SRS) performed on U.S. citizens and residents decade by decade. We then divide that number by the number of adult males in the country. The result is a rough lower bound on post-op prevalence, which we find to be about 1:2500. In other words, at least one or more in every 2500 adult males in the U.S. has had SRS and become a post-op woman. The prevalence of untreated intense MtF transsexual individualism must be many times that number, and is perhaps on the order of 1:500 (Conway, 2001).

Even with those estimates, the prevalence is probably greater given that most statistics of prevalence are cited from surgical reports of those who seek SRS.

Epidemiological studies are difficult to conduct due to variance in the clinical needs of transsexual individuals, as well as the secretive nature of the condition (Lev, 2004). It is now understood by clinicians, researchers, and gender specialists that many transsexual individuals do not seek SRS for various reasons and therefore are not included in most epidemiological studies (Devor, 1997; Lev, 2004).

### **Transsexual Individuals and the Clinical Relationship.**

A significant indicator of a successful therapeutic experience is that of therapeutic alliance (Yalom, 1980). The bond of trust between a clinician and client is paramount to successful therapy. Although there is a built-in power differential in all clinical relationships, there is a significant imbalance in the case of transsexual individuals who seek therapy per requirement to obtain a letter of referral for medical treatment they need (Lev, 2009).

Trust in the clinical relationship is two sided. The clinician can only work to his or her best ability if the client is forthcoming with their true experiences, thoughts, and feelings. A documented pattern exists whereby transsexual individuals perform a memorized narrative they believe will achieve their goal of obtaining the approval of the referring clinician (Lev, 2004).

Social work values emphasize the need to work with clients to assist them in achieving their goals and highest possible levels of functioning. Successful clinical work begins with developing trust between the clinician and client. If the client believes that a “wrong” statement may mean disqualification of something he or she desires and needs, a higher level of distrust is established (Lev, 2004). Given this power differential, there is a need to gain understanding of the experience of transsexual individuals in these circumstances in order to provide better care in the clinical setting.

Ethical concerns exist regarding psychologists, psychiatrists, medical doctors, and other service providers conducting research on their own patients. Transsexual patients tend to seek approval of those providing their care and seek to comply with expectations in order to gain further acceptance. Some transsexual individuals have felt that it is better to present inaccurate portrayals of transsexual individuals rather than have no exposure. (Prosser, 1998; Stone, 1991) Research in any form used to be considered better than having no voice or representation at all. The need for legitimacy of the condition superseded any need to share candid experiences that did not fit expectations (Meyerowitz, 2002).

All of these factors appear to have an impact on the experience of male-to-female transsexual individuals seeking gender specific therapy. The phenomenon is superficially

understood and recorded in anecdotal literature, but there is a lack of empirical data available to assist clinicians in preparing a more supportive and therapeutic experience based on empathetic understanding of this experience.

### **Significance of the Study to Social Work**

The prevalence of people suffering oppression due to their transsexual status makes it imperative that we gain an understanding of their needs and experience. With this knowledge, social workers can further their mission to empower and advocate for the disenfranchised. These social work skills have been promoted and implemented with other marginalized populations, but there continues to be a gap in understanding and sensitivity to the specialized needs and experience of transsexual individuals.

An important issue in regard to historical accounts of oppressed people is that most of the academic literature is written by individuals of the dominant culture who convey their perceptions of the minority groups, rather than members of the oppressed groups telling their own histories (Namaste, 2005). Even when sexual minorities are asked about their experiences, it is usually unclear whether they are telling their true story or attempting to please researchers and clinicians in order to gain acceptance (MacKenzie, 1994). Many transsexual individuals are accustomed to telling their stories in prescribed ways in order to gain access to medical care and procedures (Lombardi & Davis; 2006; Prosser, 1998; Walworth, 1997).

Social workers, among other helping professions, generally lack training and are ill-prepared to assist the transsexual client. If and when transsexual issues are mentioned in an educational setting, the issues are generally embedded in an overview of gay and lesbian content (Morrow & Messinger, 2006). NASW developed the National Committee



on Lesbian, Gay, Bisexual and Transgender Issues to “monitor programs of the association that affect gay men, lesbians, bisexuals, and transgenders” (NASW, 2005). The committee was originally formed in 1976 as a task force on gay issues, and officially became the Committee on Lesbian and Gay Issues in June of 1982. The word *bisexual* was added in 1996 and the word *transgender* was added in 2005.

Although there are many different professions who work with transsexual individuals in their quest for health and functioning, it is the responsibility of social workers to be in the forefront of this mission. Social work’s focus on social justice requires that we take up the mantle of vulnerable and oppressed people (NASW code of ethics, 2008). For this reason, it is crucial for social workers to also lead the way in research for this population. It is the social work skill set and professional values that allow social workers to produce respectful research and insight into the experience of the transsexual population. The findings from this study will fill an important gap in the current literature, giving voice to a population who has been studied, but not been invited to participate actively in telling their story in the research process.

Social work practice may be the professional field best suited to provide services and advocacy to individuals in the transsexual community (Lev, 2004; Levine, 1978; Wicks, 1977). The unique skill set social workers possess makes them likely partners with this population. Social workers are trained in clinical skills with individuals, couples, and families, as well as possessing the knowledge to work in social advocacy, brokering and case management. Clinical skills are needed to assist the transsexual individual in identity confidence assessment and readiness for medical intervention, and

to assist the transsexual individual in processing and healing from the stigma and oppression dealt them by a misinformed and discriminatory society.

Transsexual individuals are often impacted as much by the reaction of their social networks and families as the medical condition itself (Lev, 2004). Helping the client's system meet his or her needs as well as the advocating in the macro systems driving the stigma will allow the best functioning for the transsexual individual client. The successful transition of the transsexual individual client provides greater resources for his or her environment by better enabling the individual to function at his or her best.

Guidance and case management is frequently needed to broker the many resources needed such as hormonal treatment and surgical referrals (Rachlin, 2002). Other resources the social worker should be aware of for transsexual individual women are transgender friendly electrolysis/laser, hair and nail salons, and safe places to find appropriate breast forms and bras. Legal referrals are often needed for name changes on legal documents, employer discrimination issues, and custody problems that may arise from a gender role transition. Spousal and partner counseling may be appropriate, as well as family consultations to gain support within the family unit (Lombardi & Davis, 2006; Lev, 2004).

Further work may be needed with religious institutions in which clients are members, but may be experiencing difficulty being accepted, or need assistance with finding appropriate social networking and support. Striving to enhance social justice and the role of advocate are always significant roles for social workers, particularly when working with the transsexual population (Lev, 2004). Participating in trans-led advocacy

events is important to show community support. Social workers may also need to testify in court hearings and legal settings.

Research and knowledge development about transsexual individual's experience is limited, and there is little material in the literature submitted by social workers that address this issue. General practice and historical accounts have been published by a few social workers, but little research is available. There are two contemporary books in print by social workers. Morrow & Messinger (2006) edited a book that addresses sexual orientation and gender expression in social work practice, and clinical social worker Arlene Istar Lev published a comprehensive book titled, *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families* (Lev, 2004).

The target audience for this study will be social work clinicians and educators who work with transsexual clients or include content on gender identity in their curriculum. Findings from this study have the potential to create greater understanding of the standards and guidelines necessary for clinical work with this population. Traditionally, clinicians learn about transgender issues in graduate school settings with texts that are written by other cisgender clinicians. It is critical that the voices of transsexual clients are presented to inform this clinical work, particularly when the clinician is not transsexual. Although it is legitimate for social workers to cross clinical and demographic differences, it is always helpful to learn about the client population's experience from their own collective perspective.

DSM inclusion of gender-variance has been a challenging policy debate (Winters, 2008). The DSM was created and published by psychiatrists; therefore social workers

have had little opportunity to contribute to this policy issue. WPATH, on the other hand, is inclusive of several professions including social work. WPATH creates and reviews the standards of care for transgender patients and clients. Social workers have an important role in the active involvement and advocacy regarding policies and practices in transgender healthcare. The profession should lead the way for affirmative practice with transgender and transsexual individual clients, advocating for the end of social oppression, producing greater depth and breadth of social work research and literature on transsexual individualism, and ensuring the safety of youth who wish to explore their gender identity needs.

### **Research Questions**

The proposed research question for this phenomenological research is: How do male-to-female transsexual individuals experience a clinical relationship initiated by their transgender status? Secondary questions to be considered in the project are: What were the expectations of the transsexual individual client going into the relationship? What were the needs and fears? How do transsexual individuals experience oppression and resulting internalized transphobia when entering into a clinical relationship?

This study is written from the perspective of a natal born female with a heterosexual identity. Given that the study's participants are an oppressed population of which the author is not a member, care should be taken to understand that views and perspectives written here are knowingly from a lens of privilege.

## Chapter 2: Literature Review

*I identify as a trans-woman or a transsexual. I take enormous pride in that. And so to me the identity of being transsexual is not something I carry with any measure of shame. I see it as a badge of pride. I see it as an accomplishment.* **Participant #2**

This chapter will present an integrative review of the literature on the topic of this study. The first section will begin with an exploration of symbolic interactionism, labeling theory, and Lev's transgender emergence developmental stages model as the chosen frameworks for this dissertation research. The next section will then provide a brief overview of the qualitative and quantitative studies and journal articles in the literature regarding transsexualism. The boundaries and results of the extensive search will be outlined. The following section of this chapter will provide an overview of books and articles regarding clinical therapy work with transsexual individuals, which will be analyzed and critiqued. The final section of this chapter will present the argument for this study.

### Theoretical Framework

The use of theory is helpful as a tool to gain further understanding of a social problem. Blackwell (2000) states that theory is important because the theory components provide focus and frameworks for interpreting what we observe. He defines theory as an interrelated set of propositions that can be used as principles of explanation for a class of phenomenon. Theory is used as a framework to clarify the components of a particular social issue, facilitating the development of understanding the relationship between variables in the social issue being studied (Rubington & Weinberg, 1995). There are many theories that could be used as a framework for this study, but there are three that

best offer a framework to use while studying transsexualism. The theories chosen for this research project are symbolic interactionism, labeling theory, and Lev's transgender emergence developmental stages model. The selection of these theories reflects the changes and trends in the use of theoretical underpinnings in the study of transsexualism. There has been a relatively recent shift in theoretical focus from psychological theories that emphasize pathology and/or the search for authentic expression of gender within a binary gender paradigm, to the contemporary sociological perspective expressing the idea that gender identity and expression is problematic because those who create social rules and labels state that transsexual individuals are deviant (Hird, 2002). This theoretical shift parallels the contemporary debates regarding transgender as human variance rather than mental illness or disorder. Hird (2002) goes on to discuss the move from authenticity (binary gender conformity) focus to that of performativity; thus expressing the idea that gender is performed for the social reaction desired to affirm the internal gender identity.

While previous theoretical perspectives were based on functionalism, current theoretical trends reflect a move towards interactionism as a base. One exception, however, is Namaste (2005) who would prefer that academics and activists return to functional issues of transgender people rather than challenging the binary gender paradigm (Bess & Stabb, 2009). The paradox for this study, and using contemporary trends in theory, is that these theories are being used to develop an understanding of transsexualism to enhance functional direct practice.

This chapter section will explore the basic concepts of these theories and explicate the manner in which they assist in our understanding of transsexual individualism in a clinical setting.

### **Symbolic Interactionism.**

Symbolic interactionism evolved from concepts developed by George Herbert Mead. One of his students, Herbert Blumer, began the exploration of this concept and was the first to explore the primary elements of the theory (Johnson, 2000). This theory focuses on the symbols that individuals use to communicate, to create a sense of self (identity), and to understand their social experience. Individuals find meanings for their actions and identity through interactions and interpretations of social experience (Blumer, 1969; Hunter & Hickerson, 2003).

Sandstrom, Marin, & Fine (2006) define Blumer's symbolic interactionism:

A theoretical perspective that emphasizes how people interpret, act toward, and thereby give meaning to objects, events, and situations around them. This perspective highlights how human meanings and actions arise out of the social processes of interpretation, communication, and role taking (p. 23).

They summarize Blumer's symbolic interactionism as formulated on three basic premises:

1. Humans behave according to the meanings that things and events have for them.
2. Individual meanings of things and events stem from interaction with others.
3. Meanings entail interpretation rather than simple literal compliance with standardized expectations.

The first premise of Blumer's theory suggests that we must understand what meanings people hold towards other people, objects, and events in their lives if we are to develop an understanding of their behavior. People, objects, and events hold different meanings dependent upon how we define and act towards them (Sandstrom, Marin, & Fine, 2006). In the case of transsexual individuals entering into a clinical relationship, the experience will be different for those who see the therapist as an adversary or gatekeeper,

rather than as a guide and support towards the goal of improved health. If the therapist is perceived as an adversary, the relationship will be negatively impacted and be experienced as negative. This means clients' perception of a therapist will shape their actions while in the clinical setting.

The second premise is that meanings of things and events stem from interaction with others, which explains how transsexual individuals come to understand and define themselves (identity) from the meanings they glean from social interaction. For many, until they hear the words transgender or transsexual and obtain a definition of this experience from others, they are often bewildered about their gender dysphoria or confusion.

The third premise is that meanings entail interpretation rather than simple literal compliance with standardized expectations. This can also be used to assist us in understanding the clinical relationship experience for a transsexual client. While engaging in a clinical relationship, the tentative transsexual client may be very focused on interpreting the apparent reactions and judgments made by the clinician. When a transsexual client is concerned about obtaining an assessment appropriate for gender specific medical intervention, it often feels crucial to comply with perceived expectations of the gender specialist. After presenting an idea or issue, a simple inadvertent facial expression may be misinterpreted by the client as indicating to them that they need to shy away from further disclosure.

Symbolic interaction can be a useful framework to further develop understanding of the transsexual individual experience. It is stated in the literature that gender is socially constructed (Feinberg, 1996). Gender is performed in such a manner to inform others of



one's internal identity, and to illicit the proper and desired gender response. Gender related interaction and meaning is created through this shared performance and experience. If gender were not socially constructed, this interplay of performance would not be necessary. For the transsexual individual, the cultural accoutrements of gender are significant, because his or her genetically created body sends inappropriate gender signals. Without this shared meaning and performance, the people in the transsexual individuals' environment respond to the presented gender based on biological sex, rather than the transsexual individual's true self-perceived gender identity.

Erving Goffman, a student of Blumer, contributed a great deal of work to further develop concepts within symbolic interactionism as well as an in-depth exploration of stigma. In his essay, "*Stigma: Notes on the Management of Spoiled Identity*," Goffman (1963) wrote extensively in his exploration of social meaning and identity for people with human conditions outside the perceived majority. For people who live with a transgender identity, the social stigma is what makes social functioning complicated and unusually difficult.

While working towards presenting information indicative of female, male-to-female transsexual individuals subsequently inherit the label and stigma of deviance. There is a cross-over of ideas that connects labeling to the issues of stigma and self-fulfilling prophecy (Goffman, 1963). Deviance is a label assigned to individuals who do not conform to prescribed social norms by the persons with the power to enforce those norms. Individuals who do not conform to the gender role expectations of their assigned birth sex are perceived by society and some medical professionals as deviant. It is this

label of deviance that impacts the ability of someone with a transsexual identity to benefit from full membership in society.

### **Labeling Theory.**

Labeling theory developed as a branch of symbolic interactionism and frequently is used synonymously with it. While symbolic interactionism focuses on the shared meaning in social context, labeling theory focuses more intensely on the power of those who create the rules and label deviance. This theory was primarily developed by Howard Becker and explicated in his essay, "Outsiders" (1963). Labeling theory postulates that the majority of people in power shape the identities and social experiences of the minorities they label (Rubington & Weinberg, 1995). These labels are often based on stereotypes and perpetuate the perceived deviance of the actions of those who carry the labels (Goffman, 1963). Much of labeling theory examines the effect on the behaviors and social interactions based on the nature of the label assigned (Rubington & Weinberg, 1995). A primary posit is that individuals try on different behaviors, and choose those that elicit the reaction they are seeking in line with how they wish to be perceived. There is a cross-over of ideas that connect it to the issues of stigma and self-fulfilling prophecy (Goffman, 1963). Goffman further developed these ideas into his dramaturgical theory, using the analogy of social presence as performance similar to roles taken in theatre.

The concept that links symbolic interaction and labeling theories together is the understanding that a participant's identity is socially constructed through feedback from others in his or her social structure. In the case of transsexualism, people adopt this identity to explain their inner conflict of gender dysphoria. For example, there are varying experiences of identity, with transsexual individuals sometimes trying on the

options they are aware of before developing an understanding of their own true identity. Some transsexual individuals experiment with a “gay” identity because they are unaware of transgender and transsexual identities as possibilities.

Barris (2007) reflects on Lacan's perspective that our sense of ourselves relies solely on social meanings and labels. Although this article was focused on labeling issues for gay and lesbian people, this can be applied to transsexual individuals. The quality of transgender emergence and gender role transition is strongly impacted by the meanings given to and adopted by transgender people. When transgender people are labeled and perceived as deviant/freak/perverted, often the transgender person internalizes this and is reluctant to address his or her gender identity issues. Barris (2007) goes on to suggest that when those in the majority label sexual minorities as "unnatural," this erases the legitimacy and existence of these marginalized identities. This questioning of LGBT identities by society through deviance -- labeling them, feeds the denial and shame associated with the identity and confuses the issues of emergence and pride.

### **Transgender Emergence Developmental Stages Model.**

Lev (2004) created the transgender emergence developmental stages model based on her expertise and many years of clinical social work with transgender clients. Her model is also based on her study of existing coming out models for gay and lesbian people, adapted for the unique qualities of transgender emergence for transgender people. This developmental stages model is comprised of six stages:

- Awareness
- Seeking information/reaching out,
- Disclosure to significant others,

- Exploration - identity and self-labeling,
- Exploration - transition issues/possible body modification,
- Integration - acceptance and post-transition issues

Lev states that this model is not meant to label transgender people, and that people working through gender identity do not always go through these steps exactly in this order. The primary posit is that people who have atypical gender variance progress in their experience "from denial and self-hatred to one of self-respect and gender congruence." The argument for this model is explicated and supported in Lev's book, "Transgender Emergence" using an exhaustive literature review, including the history of transgender care, the policies and politics around transgender identity, and the many facets of clinical work with gender variant clients. This theory is also supported in the literature by virtue of its development based on previously accepted models for the LGB segments of the LGBT population.

Rachlin (2002) provides newer literature that directly supports this theory. Rachlin's stages are almost identical to Lev's (Rachlin, 2003) and states that the order of the stages is not as significant as the similarity of content. Both authors are very similar in practice, investment and participation in the transgender community, and the trans-positive perspective applied to the clinical setting. A trans-positive approach to clinical work is the practice of affirming the clients by allowing them to self-identify, working as partners towards a solution to transition and social functioning, and the eliminating a psychopathological perspective on the transgender experience. The six stages of Rachlin's parallel model are:

- Distress and confusion

- Self definition
- Exploring options
- Acting to make changes
- Coping with the consequences of transition
- Moving on with life in which gender identity is not a central issue

That these two models are nearly identical, yet developed separately by two clinicians, lends credibility to this developmental stages model. The transgender emergence developmental stage theory will be helpful to frame the experience of transsexual individual people who seek clinical services as reported in this dissertation study.

#### **Transsexual individualism as a research topic: What has been done so far?**

Until very recently, there has been a dearth of research regarding most areas of transsexual individualism (Bockting, 2008). Indeed, a database search reveals that the number of research and journal articles published in the past five years approximately equals the number of similar publications during the previous twenty-five year period. The current literature generally falls into several categories: political/activism/identity politics, and medical literature regarding treatment, surgical outcomes/GRS satisfaction, and psychopathology.

This literature review will focus on on DSM inclusion, the debate between supporters and objectors of the Bailey/Blanchard/Lawrence nomenclature, and studies that pathologize transsexual individual sexuality.

#### **DSM inclusion.**

DSM inclusion is provided as part of this integrative literature review due to the subsequent stigma imposed upon and felt by clients who seek out the assistance of

psychotherapists for affirmation of their gender identity. The decision to seek a clinical relationship initiates the practice of assigning a diagnosis by the practitioner.

Before reviewing the historical background, a brief overview of the DSM development will further enhance the depth of understanding – in context with the larger DSM history. Development of the DSM as a diagnostic tool and mental health nomenclature has developed over time and continues to be modified, with an updated version, or revision, published every few years.

The contemporary DSM is a tool developed by the American Psychiatric Association (APA) to facilitate efficacy in communication among mental health practitioners (<http://www.dsmivtr.org>). It was originally developed for use in gathering statistics of mental illness frequency during the 1840 census (APA, 1994). It grew from a single category tool (idiocy/insanity) into a more developed nomenclature for gathering statistics across mental hospitals. Attention to diagnostic inconsistencies was brought to the forefront during WWII service enlistment. National recognition of this problem was noted when significantly more recruits were turned away, based on mental health issues, from some recruitment areas of the country than others (APA, 1994).

After collaboration and inclusion of expanded diagnostic categories in the International Statistical Classification of Diseases and Related Health Problems (ICD), the American Psychiatric Association on Nomenclature and Statistics developed a spin-off book of their own from the resulting ICD-6 mental health taxonomy (APA, 1994). This new publication became what is now known as the DSM. The first two of versions (DSM in 1952, and DSM-II in 1968) were of little significance in the research and clinical practice arenas (Spiegel, 2005). These earlier versions were based on the ICD-6

nomenclature and were much thinner books in comparison to today's versions. At that time, there were only a few categories: ten for psychoses, nine for psychoneuroses, and seven for disorders of character, behavior, and intelligence. DSM-III brought significant expansion of detailed diagnostic categories, greatly improving on empirical research of mental disorders (APA, 1994). The DSM has been revised and edited numerous times over the years, and is now considered to be a living and evolving manual as science and society gain new knowledge. The DSM development and revision committees are filled with highly coveted panel positions and politically-charged selections for membership (Winters, 2008). Many of the revisions in the DSM are political in nature, and are often hotly contested debates between theoretical advocates of opposing camps (Meyerowitz, 2002).

### ***Historical Background.***

DSM inclusion of sexual orientation and gender identity has an intertwined history. Sensationalism of the Christine Jorgensen phenomenon brought the issue of transsexualism to the forefront. Her trip to Sweden for surgical intervention, and subsequent fame upon return to the United States, elicited hundreds of requests for surgical intervention by transsexual individuals (Meyerowitz, 2002). This increased awareness relating to gender variance was the catalyst for concerns regarding the physical and psychological health of transsexual individuals in particular. It was believed that the need for diagnostic nosology and treatment guidelines launched The Harry Benjamin Society, (now WPATH) (Meyerowitz, 2002). The need for nomenclature elicited the problem of identity politics being played out by professionals, with the intentional exclusion of transsexual individuals to be directly involved.

Initially, the label of invert did not distinguish between sexual identities; lesbian and gay male sexual orientation, intersex (hermaphrodite) conditions, cross-dressing (transvestitism), and transsexual individualism were all encompassed under sexual perversions and pathology. With the advent of the DSM, the term *homosexuality* was placed in the category of sociopathic personality disorders under the heading *sexual deviation* (APA, 1952). Changes in DSM II further conflated lesbian and gay male sexual orientation along with other paraphilias such as fetishism, transvestitism, and pedophilia. The initial printing of DSM II, with this nosology, did not appear to create any disturbance in the LGBT world. However, only two years later the gay and lesbian activists began lobbying for the removal of *homosexuality* from the DSM (Bayer, 1981).

With the removal of *homosexuality* in 1973 (the seventh printing of DSM II), it was replaced in DSM III with the seemingly less offensive label of *ego-dystonic lesbian and gay male sexual orientation*. DSM III was published in 1980 with *transsexuality* listed as its own category. It was later incorporated into the more comprehensive section labeled *Sexual and Gender Identity Disorders* (Lev, 2004). Harry Benjamin is believed to be the driving force behind the inclusion of transsexuality in the DSM, with the belief that it was imperative that there be nosology and nomenclature aimed at justifying medical treatment for transsexual individuals.

### ***Relationship of DSM inclusion to political & legislative process.***

Although there is no legislative involvement with an issue such as DSM inclusion of transsexual individualism as mental illness, there has been legislative involvement with mental health parity and current discussion regarding civil rights and protections for gender identity and expression. There is some belief among transgender activists that it is



more difficult to advocate for gender identity and expression as a protected right, if it is still deemed a form of mental illness (Lev 2005), rather than a birth variance or other physical medical condition. There is a perception that persons diagnosed with a mental illness are automatically considered incompetent and unable to advocate for themselves, or to understand what they may need to function in society (Winters, 2007).

Some DSM reform advocates who believe that GID does not belong in the DSM have used the historical path of lesbian and gay male sexual orientation as an example of how normative control of identity and behavior is not appropriate. Arguing the case that lesbian and gay male sexual orientation was not a mental illness, lesbians and gay men were able to have the diagnostic nosology removed from the DSM. The problem in comparing these two categories and identities is that transsexualism most often requires medical intervention, whereas lesbians and gay men do not require any medical or mental health treatment for their sexual identity alone. Many lesbians and gay men seek psychotherapy to repair damage done by stigma and oppression based on their identity, or seek exploration and affirmation of their sexual identity, due to lack of information and support during their formative years (Lev, 2004).

### ***Gender Identity and the DSM.***

Gender identity and expression has been pathologized since the beginning of western culture, although initially conflated with sexual orientation (Winters, 2007). There are no clear accounts in the literature regarding the exact history of who was the catalyst and how gender identity became an issue that deemed it a mental illness, rather than an expression of gender presentation variations (Winters, 2008). With the advent of advancing medical intervention options, growing concern over the impact of this

treatment on the individuals requesting medical and surgical procedures prompted physicians to demand nosology to legitimize and regulate treatment for transsexualism (Lev, 2004). The nomenclature and nosology surrounding gender identity and expression have gone through several revisions, using political clout and identity politics as the driving forces behind the changes. The conflicts among DSM authors, and the resulting pressures for reform from transsexual advocates, have created confusing and inconsistent criteria and confusing nosology (Winters, 2008).

The overarching problem is one of understanding and reaching agreement about what is mental illness, and what is social control of behavior, as dictated by the normative mainstream of people in power. General debate about the ethical implications of the DSM as a social work tool will not be further explored here, but acknowledgement of these issues with regard to pathologizing healthy but non-normative identities should be pointed out.

The purpose for creation of the DSM is threefold: it assists in developing continuity in nomenclature when professionals discuss cases, it is used in research, and it is used for uniformity in insurance coverage. The language, nomenclature, and criteria are designed to assist professionals across “helping profession” disciplines, as well as providing statistics for epidemiology. Proponents for DSM inclusion claim that it is the best way to legitimize the condition, and to maintain control over appropriate treatment modalities. DSM inclusion provides the necessary codes required to offer insurance coverage for the condition.

### ***The DSM and control.***

The DSM is a professional tool used by suggested agreement among researchers and mental health practitioners with no direct interference from political and legal factions. The exception to this statement is that governmental regulatory agencies use the DSM as a tool in the evaluations of the professional practice of service providers. In many places, it is still legal to oppress and discriminate against transsexual individuals; therefore, the bias and control used in the DSM against the civil liberties of transsexual individuals poses some legal basis (Namaste, 2005).

It is easiest to assume that the intentions of the DSM boards are honorable. However, there is a long and distinct history of bias and discrimination based on cultural, ethnic, racial, and gender difference of those being diagnosed from the demographics of the psychiatrists creating the nomenclature (Lev, 2004). In the past, DSM nosology managed to justify the pathologic labeling that promoted the social notions that women are weak and histrionic, and that African-Americans are naturally inferior in intelligence and social functioning (Winters, 2008). Sociologists state that the people in power are the ones who create the standards of social norms for minorities (McIntyre, 2002).

Despite the claim by many transsexual advocates and their allies that DSM inclusion promotes stigma and pathologizes natural human diversity, there are also transsexual individuals, scientists and practitioners who believe that DSM inclusion is necessary to provide quality and supervised care for medical treatment of their condition. The argument is that DSM inclusion fosters greater access to care and health parity with insurance coverage. The implied notion that this diagnosis will elevate the transsexual individual by legitimizing the condition and justifying the necessary treatment also lends

itself to the belief that the reduction of blame imbued by sexual choice will be replaced by dignity and appropriate treatment (Lev, 2004).

DSM inclusion is perceived to be implemented in part to provide better quality of life for those who identify as male-to-female transsexual individuals. Despite the debate about DSM inclusion, the majority of those on both sides of the argument agree that many of those who meet the criteria suffer greatly from the gender dysphoria. The goal is to provide relief from suffering by providing diagnostic criteria, which leads to palliative treatment. The problem, however, is in the additional harm done to diagnosed transsexual individuals – perpetuated by the stigmas of mental illness and sexual perversion (Lev, 2005).

Harm to transsexual individuals via inclusion in the DSM can be in conflict with social work values of self-determination, client rights, and self-realization. Labels can pathologize differentness and can be used to control the rights and decisions of transsexual individuals to self-identify and make their own decisions regarding medical care (Winters, 2008). This point is part of the larger debate regarding the use of DSM by professional social workers for any client seeking assistance. Nomenclature designed by non-transsexual individuals silences the voices of those with varied gender identities, and erects barriers to care for those suffering with gender dysphoria.

### ***Value Premises and Ideological Assumptions.***

The ideological assumption contained in the DSM regarding transsexualism is that the gender identity of transsexual individuals is a disorder; it is professed in the nosological category itself – Gender Identity Disorder. The DSM is designed to have professionals (in this case most often non-transgender therapists) ascertain the gender

identity legitimacy of transsexual individuals when determining the course of treatment, and whether they are appropriate for such treatment. DSM panels, authors, and task forces are charged with the role of determining what is disordered and what falls within the norms of American culture (Winters, 2008).

Transgender advocates of DSM reform maintain that the DSM criteria, especially for children, promote reparative therapy for non-conforming gender behavior and lesbians and gay men (Namaste, 2005). Although there have been many changes to the diagnostic criteria for transsexualism, many believe that this is a continuation of the status quo of pathologizing gender variance and gender expression, rather than diagnostic progress in their understanding of the condition (Winters, 2008). A radical departure would be to remove all forms of gender identity and expression from the DSM. There are proponents of maintaining a residual category for those who suffer not from the gender identity itself, but from the social oppression, stigma, and confusion that come from lack of support, medical treatment, and acquisition of general civil rights afforded to non-transgender citizens (Lev, 2005).

Feasibility of an updated DSM is challenging for the DSM board and task force assigned the duty of researching and authoring updates to the gender identity and expression nosology. Currently, there is strong advocacy and strength in numbers as transsexual individuals band together with other gender variant people, and the LGBT community, to oppose inclusion in DSM V. In the same way that *homosexuality* was removed after advocates campaigned and gained support among psychiatrists in the APA, so will the DSM board eventually be forced to recognize the need for change in DSM portrayal of gender identity (Namaste, 2005).

The general public is not overtly aware of these issues and most often do not get involved in those which do not affect them directly. What is not understood is that oppression and medical neglect harms all who experience "loss" in a community, where a human resource in the form of transsexual individuals with talents to contribute, are unable to do so due to oppression and denial of civil rights. When any group is denied equal rights, the whole community experiences loss.

DSM inclusion of transsexualism as a mental illness was intended to further the policies and mission of practitioners in a cohesive and consistent manner by citing nomenclature and diagnostic criteria for transsexual individualism. The biggest problem with this policy of inclusion is that the intended goals of legitimizing the condition, and providing relief through guided treatment, have failed. Insurance companies are still refusing coverage for the condition, frequently citing that surgery is "not standard for a mental illness." Coverage is also denied on the basis that many insurance companies and plans do not include extensive treatment for mental illness. Social healing through diagnosis (removal of patient blame), has been replaced with increased stigma of mental illness for a condition that is congenital in nature. The final goal of providing appropriate treatment through diagnostic recommendations has been biased against affirmation, and towards reparative treatment for a natural human variance.

Although many transsexual individuals still insist it is necessary to keep the DSM diagnosis to gain legitimacy and access to medical care, many transsexual individual advocates and their allies believe transsexual individualism and Gender Identity Disorder should be completely removed. Others propose that the DSM should be comprehensively revised to reflect that the gender identity itself is not a disorder, but rather that people

who live with this condition are often wounded by oppression, confusion over identity development, and depression based on social rejection.

***Bailey research debate and aftermath.***

In 2003, J. Michael Bailey published his book, *The man who would be queen: The science of gender-bending and transsexual individualism* (Bailey, 2003). This book ignited an impassioned debate reflecting the two camps of transgender activists and academics that floods the literature to this day (Bancroft, 2008). Bailey wrote his book with intention of stating his reflection of his own perception of the transgender experience in a format that would be more marketable to mainstream consumers (Dreger, 2008). The controversy over the content of the book is fueled by disagreement with the presentation of an argument that promotes transsexual taxonomy as biological males who are either homosexuals who desire SRS to make themselves more attractive to heterosexual men, or heterosexual males who have an erotic fetish towards seeing themselves as the women they desire. Transgender advocates are offended by the pathologizing, sexualizing and discounting of transgender identities (Winters, 2008).

Critics and supporters of Bailey alike have questioned his methods of data collection and lack of support from the literature in his book. The book is written without citations, and there are questions regarding his ethics. He is accused by study participants of not informing them that their conversations were part of a study that he intended to publish, that he misrepresented his credentials when writing letters of recommendation for SRS, and that he had sexual relations with one or more of his study participants. The complaint by many is that his research is presented as "scientific," yet he did not follow scholarly standards. Although the charges and investigations into Bailey's ethics and





transgender/transsexual individual scholarship and research, as well as provides some understanding of participant reluctance. It is important for researchers to be aware of the bias and resistance of research participants, given the wide-spread misconception that all researchers involved in transgender studies are insensitive, malicious, and unethical (Serano, 2007). This dissertation research study was directly impacted by the historical ramifications of the academic debate that was ignited to such a high level of intensity beginning in 2003 with the publication of Bailey's book.

### **Clinical literature.**

A significant contribution to the literature is the articles that provide guidance and direction for clinicians who are presented with transsexual clients seeking assistance. Primary texts being used by clinicians are the books, *True Selves* (Brown & Rounsley, 1996), *Transgender Care* (Israel & Tarver, 1997) *Gender Loving Care* (Ettner, 1999), and the current comprehensive handbook for clinicians, *Transgender Emergence* (Lev, 2004). Also of note are texts that describe the transgender experience such as Matt Kailey's *Just Add Hormones* (Kailey, 2005). Journal articles that produce guidelines for clinical treatment have included historical contexts of treatment trends and interpretations of how to comply with recommendations from the WPATH Standards of Care (Cohen-Kettenis & Gooren, 1999; Lev, 2004).

Many of these books and journal articles state that psychotherapy is only one piece of the clinical care needed when working with transgender clients. Many transgender clients come to a clinician with a need for referrals not only for medical interventions such as hormone therapy and body modification through surgery, but they also request referral for hair removal, vocal feminization training, and image consulting

with a wardrobe and social role presentation expert advice. These requirements of a clinician argue the significance of social work training, and professional preference for comprehensive clinical efficacy (Levine, 1978; Wicks, 1977).

There are several studies that explore the factors that may be the cause of SRS regret. Findings from these studies show that some factors reported to influence regret are: the quality of surgical results, loss of family/job/friends/social status, and/or ability to "pass" as the target gender. Reports indicate that informed and appropriate clinical work before and after SRS can reduce or eliminate the incidence of regret (Carroll, 1999). These studies and findings are significant for clinicians to be aware, as well as informing the context of this research.

For many transsexual individuals, it is the understanding that body modification and medical intervention providers require referral letters from mental health providers as outlined in the Standards of Care that brings them to clinicians. Findings of several studies have revealed that participants lied to their therapist about issues they perceived to be a threat to receiving the needed referral letters for hormones and surgery. Walworth (1997) conducted a study regarding the kinds of issues that transsexual participants admit to lying about when seeing their therapist. They stated that they lied about certain aspects of their identity and experience for fear of rejection, invalidation, or most importantly, the denial of a referral letter for hormones or surgery. The findings in this study list sexual arousal in response to wearing women's clothing, preferring girls toys and games as a child, and attraction to men as primary areas that participants lied about to their therapist.

Rachlin (2002) published an article about a study that sought to gain understanding of transgender individuals' experience of psychotherapy. Her study used

quantitative survey research methods with a sample of 93 participants. The survey questions asked participants why they sought treatment, what they looked for in a therapist, their opinion about their therapists' level of competence in gender issues, and the outcome of the treatment. Rachlin's findings were helpful informing clinicians about what is helpful for transgender clients. She reported that many survey respondents saw a therapist for general life issues earlier in their life, and sought a gender specialist at a later point in time to address their gender issues. The findings also supported other literature (Johnson, 2001; Green, 2008) indicating that there was higher patient satisfaction and better treatment outcomes when transgender clients saw a provider with experience in transgender care. Additional findings report that participants of this study liked therapists who were more flexible in their understanding and treatment options, and who demonstrated respect for transgender identities.

Rachlin's (2002) findings are relevant to this study though different from this research for several reasons: Rachlin's study was published 8 years ago and 11 years have already passed since the initial data was collected. Due to the increase in media and Internet visibility, there is a possibility that some of the findings could be outdated. In addition, she employed a quantitative design and participants voices describing the meaning of their experience were missing. Women are traditionally more compliant and comfortable with the idea of seeing a therapist (Singleton & Straits, 1999) so this sample population may have a very different perspective than male-born women. For these reasons, this study adds relevant results for male-to-female transsexual individuals.

Bess and Stabb (2009) published a study that explored the therapeutic alliance and satisfaction between transgender clients and their therapists. This study was qualitative

and sampled clients who lived at least 3 months in their target gender. Both male-to-female and female-to-male participants were included in a maximum variation sample, with ages of participants ranging from 36-60. The challenge of this sampling strategy is that male-to-female and female-to-male participants can potentially have different perspectives and motives based on birth sex socialization and target medical options.

Findings for the Bess and Stabbs study indicated that most participants were satisfied with their psychotherapy experience, although criticism of therapists included complaints that clinicians approached transgender therapy clients with an "attitude of eliminating pathology rather than facilitating wholeness. The participants . . . stated the importance above all else of making connections with transgender people, so that they are seen for their humanity rather than their novelty."

Bockting et al (2004) also studied patient satisfaction with transgender health services. This research report describes a series of studies that investigated different aspects of transgender health care, including medical (physical) care and mental health services at a university-based sexual health clinic. Quantitative survey methods were used over a period of several years to assess patient satisfaction. Findings were that patients were satisfied with their treatment and services received. Challenges to this kind of study point to the tendency for marginalized people, particularly stigmatized populations, who are likely to report satisfaction regardless of their true feelings and experiences based on their need to please their providers and/or the researchers (Patton, 1990).

### **Gaps in the Research Literature**

This literature review demonstrates that there are two distinct areas of scholarship regarding transgender/transsexual studies. Much of the research being conducted has

been medical in nature, assessing the body modifications desired and the efficacy of hormonal and surgical methods. Research in the hard sciences also consists of studies seeking an answer to the question of etiology for gender variance. In the social sciences camp, there are numerous studies seeking to reduce regret for transsexual individuals who have SRS, studies about the sexual orientation of transsexual individuals, and theoretical studies about gender identity and gender politics.

Qualitative methods used in some recent studies have afforded researchers an opportunity to learn more about the clinical experience from the perspective of transgender clients. However, most studies used quantitative survey methods that exclude the voices and meaningful experience of the transsexual population.

A major gap in the existing research is the lack of focus on the experience of racial and ethnic minorities. Cultural minorities are rightfully reluctant to trust researchers from a dominant group. This population experiences double jeopardy in regard to the labeling and stigma discussed earlier. Thus, their experience is important to understand in relation to clinical relationships.

## **Chapter Summary**

This chapter reviewed the literature on transsexualism relevant to the research question for this study. Although, there have been few studies in regard to transsexual individuals' experience of therapy, there is literature that help us to understand some of the key issues surrounding transsexual individuals in therapy. Most significant is the literature that addresses the issue of DSM inclusion. When gender variance is labeled as mental illness, this perpetuates the belief that gender variance is a perversion or disorder of psychological well-being. Given the possible pathologizing of a birth variance, the

professional community then deems transsexual individuals incompetent to make decisions regarding their own medical treatments. The irony is that in order for transsexual individuals to receive medical care, they are required to be labeled as mentally ill to do so (Winters, 2008).

Also, tangential to the study of transsexual individuals' experience of psychotherapy, is the impediment to research sampling of this population in part due to the Bailey debate. The Bailey book and its subsequent conflict in the gender community have spotlighted the already contentious relationship between the medical/academic communities, and the transgender community. Distrust of non-transgender professionals and researchers is valid based on the historical treatment of gender variance, both theoretically and in direct practice (Cole et al., 2000; Gainer, 2000; Korrell & Lorah, 2007). However, as the treatment of transsexualism has advanced for some professionals and researchers, there is still resistance to the perception that gender variance is a normal course of human existence. The DSM and Bailey debates have crystallized this conflict of paradigms.

Three sociological theories were briefly reviewed as frameworks to guide our understanding of transsexual individuals' experience of the clinical experience. Symbolic interactionism describes the shared meaning that shapes their identity, labeling theory explicates the impact of power differentials, and transgender emergence provides a description of the transition process for transsexual individuals.

### Chapter 3: Methodology

*Let me tell you something: trans people have already been studied. We've been interviewed, sampled, tested, cross-referenced, experimented upon, medicated, shocked, examined, and dissected post-mortem. You've looked at our chromosomes, our families, our blood levels, our ring fingers, our mothers' medicine cabinets, and our genitalia (over and over again with the genitalia- stop pushing condoms on us, dumbass, we know what they're for.) You've watched us play with dolls, raise children, fall in love, look at pornography, get sick, die, and commemorate ourselves. You've listened to our ears. You've listened to our fucking ears! But you've never listened to our voices and you need to do that now.*

*-A. Tagonist*

#### Qualitative Research

The research design chosen for this study is qualitative, based on a phenomenological approach. Creswell (1998) defines qualitative research as:

An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of information, and conducts the study in a natural setting (p.15).

Because previous research has focused on medical diagnosis and body modification treatments, the qualitative approach fills a gap in research that elucidates understanding from the experience and perspective of transsexual individuals themselves. This type of approach to inquiry allows people who are members of the marginalized population being studied to be co-researchers, to assist in the inquiry and discovery of findings. Qualitative research contrasts with the findings in quantitative study due to the open-ended nature of the inquiry. More detailed information can be explored through thick description using the words of the participants. One key phrase in Creswell's definition is that of "holistic picture," describing an approach that includes more opportunity for discovery than that of predefined and close-ended questions. Manipulated statistics leave analysis void of direct representation of a participants' experience. A "holistic picture" captures more depth and breadth of the entire experience, rather than

focusing on researcher selected target points as in a quantitative research study (Patton, 1990).

The intention of social work research is to gain understanding of a social issue, in order to improve the quality of intervention and assistance to the marginalized population under consideration (Reissman, 1994). The open-ended questions in a qualitative study allows the participants to inform us of what their needs are, rather than asking them if they agree with our preconceptions of what they need. The holistic approach provides more latitude in understanding the entire experience as opposed to a limited portion of the experience possibly taken out of context. The detailed responses allow the participant to share the full range of experience; all within the context they describe (Kvale, 1996).

Qualitative research uses the researcher as instrument and in-depth interviews with people who have experienced the phenomenon being studied (Silverman & Marvasti, 2008; Kvale, 1996). Whereas quantitative social research also uses self-report in the form of questionnaires, qualitative study has flexibility by using open ended questions to increase the depth and breadth of response (Patton, 1990). It is through this depth of response that researchers are better able to capture the essence of an individual's experience of a phenomenon. Quantitative questionnaires use fixed questions based on what is already known. This pre-set structure limits findings of experiences not yet known (Reissman, 1994). Although there has been research regarding medical treatments, etiology, SRS satisfaction, and political issues, there has not been extensive research regarding the actual experience of transsexual individuals in their social setting from their perspective. Because understanding the psychosocial experience of transsexual individuals is still emergent with regard to research and development of a knowledge



base, it is helpful to use qualitative methods to tease out the essence of experience not yet explored or understood.

Qualitative methods are the better choice for exploring the complex question regarding male-to-female transsexual individuals' experience of clinical relationships initiated for assistance with transgender issues. Due to the ability to gather greater depth and breadth of data, qualitative research is currently the best way to gain an understanding of a population's experience of a phenomenon that is not yet fully understood (Singleton & Straits, 1999). Phenomenological methods are an excellent way to study the experience of a population that has frequently been passed over in academic understanding of their own social identity (Moustakas, 1994).

### **Phenomenology.**

Of the possible qualitative research design options, phenomenology is the best methodology framework to accomplish the objectives of this study. Patton (1990) succinctly states that a study using a phenomenological approach "is one that focuses on descriptions of what people experience and how it is that they experience what they experience" (p.71). Phenomenology was developed over many years, beginning with mention in the work of Kant in 1765, and further developed by Hegel with a more technical meaning, "referring to knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one's immediate awareness and experience" (Moustakas, 1994, p.26). Descartes later influenced Husserl's development of the concept of *Epoche*, the method whereby one eliminates presuppositions. Moustakas (1994, p. 27) further develops the phenomenological perspective by stating, "Perceptions of the reality of an object is dependent on a subject." The meaning of this statement in the

phenomenological method is that knowledge is brought forth through the lens of the person perceiving an "object." This means that the understanding of an experience is made known by the researcher through words and interpretations of observations of a phenomenon.

Because male-to-female transsexual individuals have historically been studied as unusual segments of the human population, this study's intention is to give voice to those being studied. Previous research has generally been conducted by cisgender researchers through the lens of cisgender (non-transgender) and heterosexual privilege and bias (Serano, 2007). Phenomenological methods allow research participants to share their experience by opening up the answers to the question to be directed by that which the participant deems important. Analysis and findings therefore become a truer reflection of the essence of the experience being studied. The open-ended format provides an opportunity for participants to share aspects of the phenomenon that may not have been addressed if closed-ended questions were used as in a quantitative study (Moustakas, 1994).

An important component in qualitative research is the action of bracketing, allowing the researcher to bring forward his or her biases and work towards setting those aside. Also known as *Epoche*, this is a significant step in a phenomenological study (Patton, 1990). By bracketing his or her own presuppositions and bias, the researcher is better able to then move forward with an awareness while collecting data and performing the data analysis. Periodic reviews of researcher bias allow for greater credibility in the research findings. The researcher is able to reflect back to the *epoche* to ensure that the

findings are authentic, rather than confirmation of presuppositions (Silverman and Marvasti, 2008).

This phenomenological study followed currently practiced and accepted methodology, using the researcher as instrument, epoche'/bracketing, and collecting data from intensive face-to-face interviews. Kvale (1996) describes qualitative research process as either data miner or traveler. The objective of qualitative research and phenomenology is to use words to describe experiences that are difficult to quantify. Using an interview technique as data collection allows a deeper understanding through asking questions of those who have experienced that which the researcher is investigating. The researcher as instrument includes both the vehicle for the interview, as well as the tool for analysis and interpretation of findings. Intensive face-to-face interviews involve the researcher and study participant in long, structured question and answer sessions, lasting 1-2 hours. This longer length of time allows researcher to explore and obtain more details from the participant.

This qualitative research used an emerging design, allowing the researcher to adapt and change as the study progressed. As themes emerged during the series of interviews, additional information was obtained with refined and additional questions. Continuous analysis and review took place during the data gathering process to inform the structure and sequence of questions in subsequent interviews, as well as decisions regarding sampling. The decision to stop collecting data was reached at the point of saturation - themes were repeated across analysis of completed participant interviews, by themes repeating across data analysis of completed participant interviews; there were no new descriptions of the phenomenon.

### ***Immersion.***

Traditionally, extensive immersion is reserved for field observation techniques such as ethnography (Patton, 1990; Silverman, 2008), but it was employed with this population due to the level of oppression and distrust of researchers in the field of transgender studies. I developed an understanding of the need for networking and trust building while doing a qualitative research class project (Whitfield, 2002). Participants were recruited at the annual Gold Rush conference for a small study. It was at this conference that I first learned of the controversy surrounding a study by J. Michael Bailey (2003), for his book, "The Man Who Would Be Queen." During and after recruiting and conducting research at that time, I received hostile comments from prospective participants, as well as follow-up hate emails. This distrust and hostility towards research with the transgender community continue, as observed in this discussion list posting: Fuck You and Fuck Your Fucking Thesis: Why I Will Not Participate in Trans Studies (Tagonist, A., 2009).

Many qualitative experts recommend immersion of the researcher into the population community (Patton, 1990; Rubin & Rubin, 1995). The concept of immersion evolved from ethnography studies with researchers who are not participants of the population they observe. By becoming familiar, researchers are better able to capture authentic data due to stronger issues of trust and mutual comfort between researcher and participant. Immersion can take place over a period of time or with intensive continuous cultural participation (Kvale, 1996). Although a researcher is not a member or participant of the population he or she study, there is the possibility of cultural understanding through shared meaning and through extensive interaction (Douglas, 1976).

I was able to gain access and trust through extensive immersion, which enabled me to be accepted and referred to potential participants via key informants. It is imperative for a cisgender researcher to fully explicate and bracket prior assumptions based on privilege and lack of personal experience in the studied identities. I have experienced a ten-year history of immersion in the local, national, and international transgender community through prior pilot studies which included face-to-face interviews, clinical expertise based on direct practice with transgender clients, and extensive volunteer hours at the Gender Identity Center of Colorado. These experiences provided clarification of this participant group and furthered the depth of understanding of transsexual individuals' fear of researchers (Whitfield, 2001 & 2002).

For a decade I have conducted and attended workshops at the annual Colorado Gold Rush national conference. This conference organized by the Gender Identity of Colorado not only brings presenters and attendees from Colorado, but also from states across the US, to exchange knowledge regarding transgender issues and care. Each workshop is reviewed and approved for quality and pertinence to the transgender experience. The conference and workshop schedule is designed to encourage socialization and time for intimate conversations with new friends and colleagues, including formal meals with keynote speakers. This style of conference design has afforded me the opportunity to engage with several transgender people as well as influential leaders in the transgender community. This annual event has included a full immersion of 15-hour days over a period of several days, providing further enhanced acceptance of me as a safe visitor and ally in the transgender community by leadership informers and closeted attendees alike.

Acceptance by the transgender community is manifested in frequent, direct, and verbal expressions of appreciation as well as presentation of a merited award on behalf of the Gender Identity Center of Colorado. This award was presented to me as a supportive member of the community towards transgender people and the Gender Identity Center of Colorado.

My reputation from within the community, along with well-honed clinical social work listening skills, provided a dynamic of trust to promote the sharing of private experiences. This trust was further supported when my reputation was sought out by potential participants. "Oh, I looked you up," was stated by several participants before accepting the invitation to participate. Through social networking and my professional website which states my perspective, participants learned enough of my transgender alliances to establish trust in my motives.

I have worked in private practice as a clinician working almost exclusively with transgender clients since 2003. My clinical practice and experience includes gender identity assessment, case management, brokering of resources, and psychotherapy when needed. Part of that clinical experience also encompasses the process of assessment and preparation for referral to transgender medical providers. In my practice I use the Harry Benjamin Standards of Care as a guideline for assessment and template for the required letters of recommendation to obtain medically necessary hormone and/or surgical procedures for gender confirmation.

***Presuppositions.***

This research report is being written from the perspective of a researcher and clinician with several years of immersion in the transgender community. Through

experiences in private practice, graduate level course requirement research, and personal connections, I have anecdotal evidence and professional experiences that sway presuppositions going into this project. Intense conversations at conferences, online, and in person have made me painfully aware of the animosity directed towards mental health providers who treat transgender clients. Based on these considerations, my presuppositions focused on the presumption of fear, resentment, and anxiety on the part of transsexual individuals who have used mental health clinicians to obtain approval for transgender healthcare. It was important in the research process to explicate my biases and suspend pre-judgment and expectations in order to conduct valid interviews. An awareness of my own defenses against animosity was paramount to successful interviewing and data analysis.

Presuppositions based on my clinical experience were as follows: participants who were resentful of seeing a mental health provider for assessment to obtain permission and approval for transgender medical care will report a softening of this position if they were seen by a gender knowledgeable clinician with a contemporary approach; younger participants will express more resentment of these guidelines because they have identity confidence based on less experience with oppression and societal ignorance of transgender issues; many participants will express appreciation for the assessment process due to a successful transition; those with co-morbid conditions will express less satisfaction based on their post-op experiences with these other circumstances.

## **Research Design**

### **Sampling strategies.**

#### ***The sample population and sampling criteria.***

To achieve a realistic and manageable sample based on phenomenological traditions, a target series of 10 or more participants were sought based on convenience sampling for individual interviews. Care was taken to narrow participant criteria selection to increase credibility while adding demographic variety to increase depth and breadth of voice. A participant who has a higher socioeconomic status will most likely share a different perspective than one who has less access to care. Mental health assessment may be resented as more of an intrusion if it is financially burdensome. The participant's age of transition and access to mental health and medical intervention may also add a different experience than a younger participant who had greater information in formative years due to increasing visibility and internet access.

The participant selection criteria for the study followed these guidelines: Male-to-female transsexual individuals over the age of 21 and at least two years SRS post-op who sought clinical assistance before or during gender role transition. For ethical reasons, current or former clients of the researcher were not considered. Participants were required to be over the age of 21 to avoid involving minors who may require consent from adult parents. The rationale for the 2 years post-op is to protect the transsexual participants and to encourage transparency in the interviews. Participants who are pre-op may still be hesitant to share some aspects of their experience for fear that word could somehow get back to their therapist, removing the possibility for receiving a surgery referral letter. Other concerns may be that participants may still feel vulnerable regarding a researcher's



perception of them as viable candidates for surgery. Doing the interviews with participants who are post-op leaves them in the position of having nothing to lose regarding medical care when statements are made about their experience. The two year post-op time frame was arbitrarily chosen to give participants more space from the intensity of their SRS and transition completion.

The decision was made to have the sample population focus only on male-to-female transsexual individuals because the experiences differ in so many ways that it could confuse the results. The sample population for this study focused on adult male-to-female transsexual individuals. The experience of a male-to-female identity is very different from that of female-to-male (Devor, 1993) so it was important to narrow the sample. Another factor that differentiates the two populations is the need for clinical approval letters. Since the phalloplasty surgeries are yet to be consistently successful or financially attainable for most, the need for SRS approval is significantly reduced in numbers from those of male-to-females seeking vaginoplasty (Rachlin, 1999).

The sampling strategy for this study was a blend of snowball sampling, criteria sampling, and purposeful sampling. Patton (1990, p.169) defines purposeful sampling as seeking "information rich cases" to gather depth of data and understanding of a subject matter. This also follows in line with snowball sampling, the strategy and method whereby the researcher obtains potential participants via word of mouth from key informants and other study participants. This happened a few times during my search for participants. Due to financial constraints, I only travelled to cities where I could interview two or more participants. As I received responses to my internet postings, I made known

this requirement to the respondents. The respondents frequently suggested that they could assist me in recruitment through their local associations.

Patton (1990) continues on to explain criteria sampling as the method of choosing specific participants who fit clearly defined participant criteria. Each potential participant was pre-screened to make sure they met the study criteria. Purposeful sampling sought to include transsexual individuals who experience a clinical relationship in earlier times when therapy was more traditional and focused on gate-keeping. In these earlier years clinicians were not as knowledgeable as their contemporary counterparts. For this reason, the contrasting purposeful sampling included people who have transitioned more recently, with therapists who have a more updated understanding of the care necessary for transgender clients. More recently, transsexual individuals have had access to experienced therapists who are knowledgeable to a greater extent about transsexual individual issues.

My level of immersion was a drawback for sampling the transgender community in Colorado. Due to the intensity and reputation of my work in the Colorado transgender community, it became evident that I needed to find participants from out of state or who transitioned in other states. The objective for participants was to have candid responses to the research questions. The concern was that those who know me personally from my local involvement may soften or alter their responses to please or avoid offending me. The other consideration is that there are very few gender specialists locally. The perception on the part of the participants may be that if they received services from a local clinician and expressed any dissatisfaction during the interview that I might report this to their clinician or be defensive on the part of a colleague.

Cost limitations required a convenience sampling of participant recruitment per access via gender conference attendees, Internet transgender discussion lists, Gender Identity of Colorado referrals, and clinical gender specialists' referrals. An attempt to achieve some heterogeneity prompted recruitment from a variety of types of communities (e.g., rural, urban, or the suburbs). Cross-sectional analysis examined the impact of advantages for transsexual women with financial resources, proximity to specialized care, educational opportunities, and generational differences based on a socially progressive societal knowledge regarding transsexualism as a medical rather than moral issue.

Networking strategies in preparation for this study included contemporary methods and use of internet sites. I established a facebook account and subscribed to a yahoo discussion list as well as becoming an approved member of trans-academics.com. Other internet networking recognition came from gaining approval for listing on trusted sites as a gender therapist. The recognition and approval by transgender leaders has strongly contributed to the credibility and trust in me as therapist and researcher.

The intention of this study is to give voice to this population by directly asking them to share their experience. It is also important to note that the ideas and literature presented within this proposal is not specifically representative of racial minority experience as members of these groups. Due to the further marginalization and lack of access, little research has successfully represented Lesbian Gay Bisexual Transgender (LGBT) experiences of racial minorities. Although some research has focused on gay men and lesbians of color, there is a dearth of research to explore and understand the experience of transgender racial minorities. This study's sample is therefore to be understood to be generally of Caucasian members of the male-to-female transsexual

community, except where specifically noted. Many times racial minorities may or may not be included in studies reported in the literature review, but often they are swept into aggregate data based on gender identity/expression demographics. Although every effort feasible was made to include more racial minorities in sampling, this was not possible. The racial diversity represented in the sample was limited to two Latinas and one person who identified as "mixed."

***Description of the sample.***

Although sampling numbers were dictated through the process of data analysis leading to saturation, the expected number of interview participants was approximately ten; however the total ended up being twelve. They ranged in ages from 30 to 64, and their years post-SRS ranged from 20 months to 33 years. Due to travel expenses and limited resources, participants were chosen from states and locations where at least two interviews could be conducted. Initial contacts with participant volunteers provided additional participants through snow-ball sampling. One participant provided four additional volunteers, two of which were eliminated due to demographic redundancy. Four participants were visiting from other states, and transitioned in other states, but were interviewed in Colorado.

The sample was diverse in religious affiliation (Agnostic, Buddhist, Catholic, Christian, Fundamental Christian, Jewish, Progressive Methodist, Spiritual, and Open Spiritual), marital status (divorced, single, married to female, married to male, and domestic partnership with pre-op MtF), time lived in Real Life Experience (RLE) from 6 months to 5 years, and age of transition onset ranging from 14-56 years old. Participants

resided in Washington, Arizona, Oregon, Hawaii, Ohio, and California. Refer to Table 1 for characteristics of the sample.

## PARTICIPANT DEMOGRAPHICS

	My Age Now	Current Partnership or Marital Status	Partnership Status Before Transition	Religious Affiliation	Ethnicity	Length of Time in Therapy	Length of RLE	Income Before Transition	Income Since Transition
#1	57	Single	Divorced	Open Spiritual	Latina/ Anglo	7 yrs.	3 yrs.	\$75K-99K	\$25K-49K
#2	47	Divorced	Divorced	Agnostic	Caucasian	4.5 mos.	14 mos.	\$50K-74K	\$50K-74K
#3	64	Divorced	Divorced	None	Caucasian	6 mos.	5 yrs.	\$25K-49K	\$25K-49K
#4	67	Single	Single	Fund. Christian	Caucasian	12 mos.	12 mos.	\$0-24K	\$0-24K
#5	59	Divorced	Married - F	Catholic	Caucasian	5 yrs.	11 mos.	\$25K-49K	\$29K-49K
#6	30	Single	Single	None	Hispanic/ Caucasian	8 mos.	2 yrs.	\$0-24K	\$0-24K
#7	51	DP w/ pre-op M-F	Single	None	Caucasian	11 yrs.	2 yrs.	\$50K-74K	\$50K-74K
#8	40	Divorced	Divorced	Buddhist	Caucasian	1.5 yrs.	4 yrs.	\$25K-49K	\$25K-49K
#9	51	Divorced	Married - F	Prog. Methodist	Mixed	2 yrs.	1.5 yrs.	\$100K-149K	\$100K-149K
#10	61	Married - M	Single	Jewish	Caucasian	10 yrs.	4 yrs.	\$0-24K	\$0-24K
#11	38	Married - F	Married - M	Catholic	Caucasian	2.5 yrs.	2.5 yrs.	\$100K-149K	\$50K-74K
#12	49	Separated	Married - F	Christian	Caucasian	1 yr.	6 mos.	\$75K-99K	\$75K-99K

Table 1

### **Data collection.**

Data collection for this study focused on in-depth interviews with post-transition clients. Twelve participants were recruited through key informants and selected after a screening process to ensure the participants met the study participant criteria. Potential participants were instructed to initiate contact via email to ensure that they did not feel coerced to participate.

Initial interview duration averaged 60 to 75 minutes in length, with one interview at 50 minutes and one at 105 minutes. All participants completed a demographic survey and signed the informed consent form. Each interview began with an explanation of the purpose of the study, a review of my credentials, and a review of the informed consent. They were reminded that they were under no obligation to answer any question that made them uncomfortable, and that they could stop the interview at any time. The chosen format was a flexible interview schedule design (see appendix E) to guide the conversation with each participant while allowing for unanticipated responses and insight (Patton, 1990; Rubin & Rubin, 1995). Questions were open-ended, and redirect questions were used if so indicated. Examples of questions asked in the interview were: "Tell me about how you first came to understand your gender identity?" "When you began coming out to yourself, what was your experience of seeking assistance to work towards resolution?" and, "How did you find and choose the therapist you saw?" Follow-up and clarifications can be encouraged with probing statements such as, "Tell me more about that process for you." A follow-up interview with a few select participants allowed for greater depth and breadth of data, as well as reflection for credibility opportunities. Interviews were recorded with consent, and transcribed for data analysis.

### ***Documentation processes.***

Interviews were recorded with a digital recorder with a cell phone recorder used as a back-up device. Recordings were then submitted to the transcriber who used a transcription pedal and word processor to transcribe all words spoken in the interviews. Digital recordings were archived on coded CDs and backed up onto an external drive. Participant names were coded and only associated with the recordings in one document on a flash drive, seen only by the researcher. Transcribed interviews were reviewed for accuracy and printed for manual analysis. Through the analysis process, subsequent copies were altered and coded, leaving the originals in their respective files on an external flash drive that only the researcher had access to. Demographic surveys, consent forms, and working documents were all filed in a private office where only the researcher could access them. At the end of the research project all data files, recordings, and transcriptions were removed from the primary computer and burned to DVD. These final DVD copies are locked in a digital safe box in the researcher's office. Original recordings were erased from the recording devices.

A travel netbook was used to record field notes and saved to a flash drive as backup. The act of bracketing presuppositions was recorded as well as observations post-interview regarding perceptions of the interview process for each participant. Field notes were also recorded during immersion experiences at a Transgender Day of Remembrance and the 2010 Gold Rush conference. Previous field notes from prior studies conducted at the Colorado Gold Rush in earlier years were also reviewed. Research memos of the data collection process were used to inform the emergent design. These notes were



particularly helpful in designing questions for follow-up interviews and key informant member checks.

### **Data analysis.**

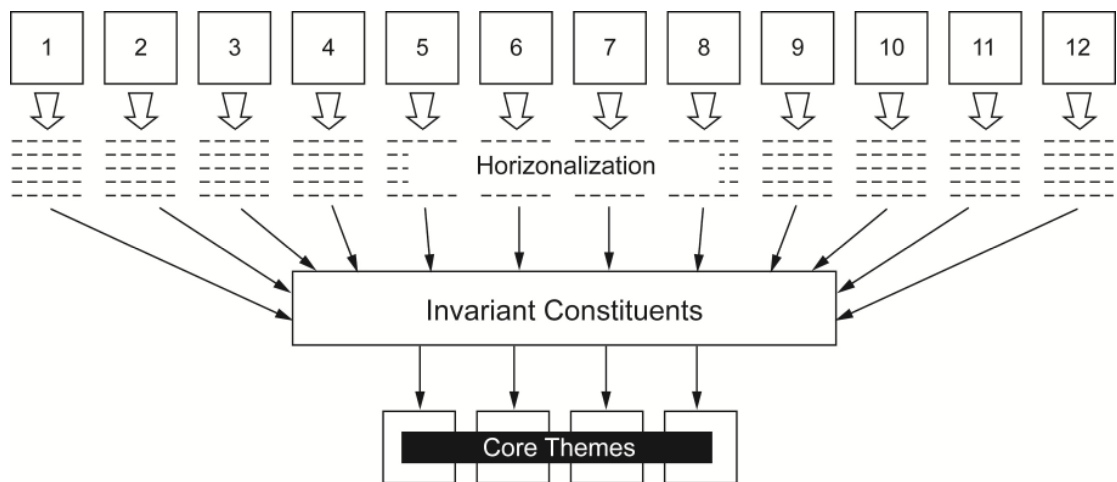
The data analysis method chosen for this study was Moutakas' modified version of the Van Kaam method of analysis. This method of analysis involves several steps of reduction and elimination, preliminary grouping, identification of themes, and creating a composite of the textural and structural descriptions found in the data transcripts. In the final step, the essence of the phenomenon is presented and described. Following are the steps listed in more detail per Moustakas (1994, pp. 120-121).

The first step was reading and re-reading the transcripts in their full form. The exercise of editing for typographical errors and color coding my questions to differentiate from participant responses allowed for line-by-line reading of the transcripts. After this, my questions and probes were removed, as well as preliminary introductions and instructions. I then listed each statement, giving them all equal weight. This step is called horizontalization.

The next step of the process is called reduction and elimination. During this phase, I checked each horizon to see if it a.) Contained a moment of the experience that is necessary for understanding it and b.) is it possible to abstract and label it? I then also eliminated those horizons that were overlapping, vague, or repetitive. The remaining horizons are then called invariant constituents.

After identifying the invariant constituents, I then coded and grouped them according to core themes of the experience (see figure 2). These invariant constituents were applied to the complete participant record for final verification and validation

(Moustakas, 1994). The final invariant constituents and themes were then listed in textural and structural descriptions. Textural and structural descriptions are defined differently by different authors. For Patton (1990), textural description refers to "an abstraction of the experience that provides content and illustration but not yet essence." He continues on with structural description being explained as "the researcher looks beneath the affect inherent in the experience to deeper meanings for the individual." Moustakas (1994) offers a converse definition of both concepts, with textural description meaning to be the essence of the experience, and structural description is defined as the context of that experience. The interpretation of these theoretical concepts chosen for this study was Moustakas' (1994) version, to keep in alignment with the Moustakas data analysis framework. It seemed most logical to follow just one theoretical author in the data analysis process.



**Figure 2**

Three study participants were contacted via email and all three agreed to participate in a brief phone follow-up interview. The composite textural and structural descriptions were reviewed for each follow-up interview and feedback was recorded and

transcribed. These transcriptions were reviewed and manually analyzed. Minor adjustments were made to reflect the participant feedback. Member checks conducted in this fashion are described by Miles and Huberman (1994) as further assurance of credibility of findings.

This final composite textural and structural descriptions were then shared with key informants for further triangulation and validity checks, thereby strengthening the validity/credibility of the data (Miles & Huberman, 1994). Creswell (1998) describes key informants as people who can provide insights into the population being studied, as well as those who can provide contacts for those they believe to possess significant contributions to the focus of the research study. The transgender community leaders chosen for this portion of the data analysis were those who I have had contact with through my immersion experiences. One is the executive director and prominent community leader familiar to me for years through contact at the Gender Identity Center of Colorado and a decade of interaction and co-research at the Colorado Gold Rush annual transgender conference. The second key contact is the international foremost expert and trans-advocate regarding issues surrounding DSM inclusion of transgender individuals. The third contact is a member of the transgender community who frequently attends support groups as a mentor to newer members. Each of these key informants was contacted via email to request a consultation session, to which they agreed.

This framework was an appropriate choice because it is validated through frequent use in phenomenological studies, as well as structured and flexible enough to seek truth and voice of those experiencing the phenomenon. Researcher bias is clearly

stated and bracketed to enhance validity. Thick description and direct quotes used in phenomenological studies give voice to this oppressed population.

### **Credibility and Trustworthiness.**

Credibility of qualitative research is dependent on rigorous data techniques and the credibility of the actual researcher (Patton, 1990). Triangulation of findings with members of the transsexual individual community has defined the credibility of the research results (Miles & Huberman, 1994). To ensure that my findings were accurate, I had meetings with key informants from the transgender community with whom I am familiar.

Credibility was executed through the methods of follow-up interviews with participants, explication of epoche' through researcher field notes and reflection back to existing literature. Reflecting and paraphrasing during interviews, along with summary post interview and aggregate reporting for triangulation of analysis, fostered validity within each participant unit. Findings were reported to members of the community who identify with these participant groups to ensure validity, credibility, and trustworthiness of results.

## Chapter 4: Findings

*It's such a profound thing that I describe as being a roller coaster ride. When you get into it it's wild and it throws you around. You don't know where its going to go. It's a bit frightening. And a when it comes to the end, you are rolling back into the station at the end, you say, "Wow, that was a hell of a ride" and you want to go on it again, but you can't. It's one of those things you can't really realize what an amazing experience it is until it's over. - Participant #2*

A desire to gain understanding of a clinical relationship from the perspective of transsexual individuals themselves prompted this study using phenomenological methods. The open-ended question format allowed the twelve participants to freely share their experiences. It quickly became apparent after the first two interviews that isolating the clinical experience from the background of the participant and the events leading up to her engagement with a therapist would lose the context and meaning of the findings.

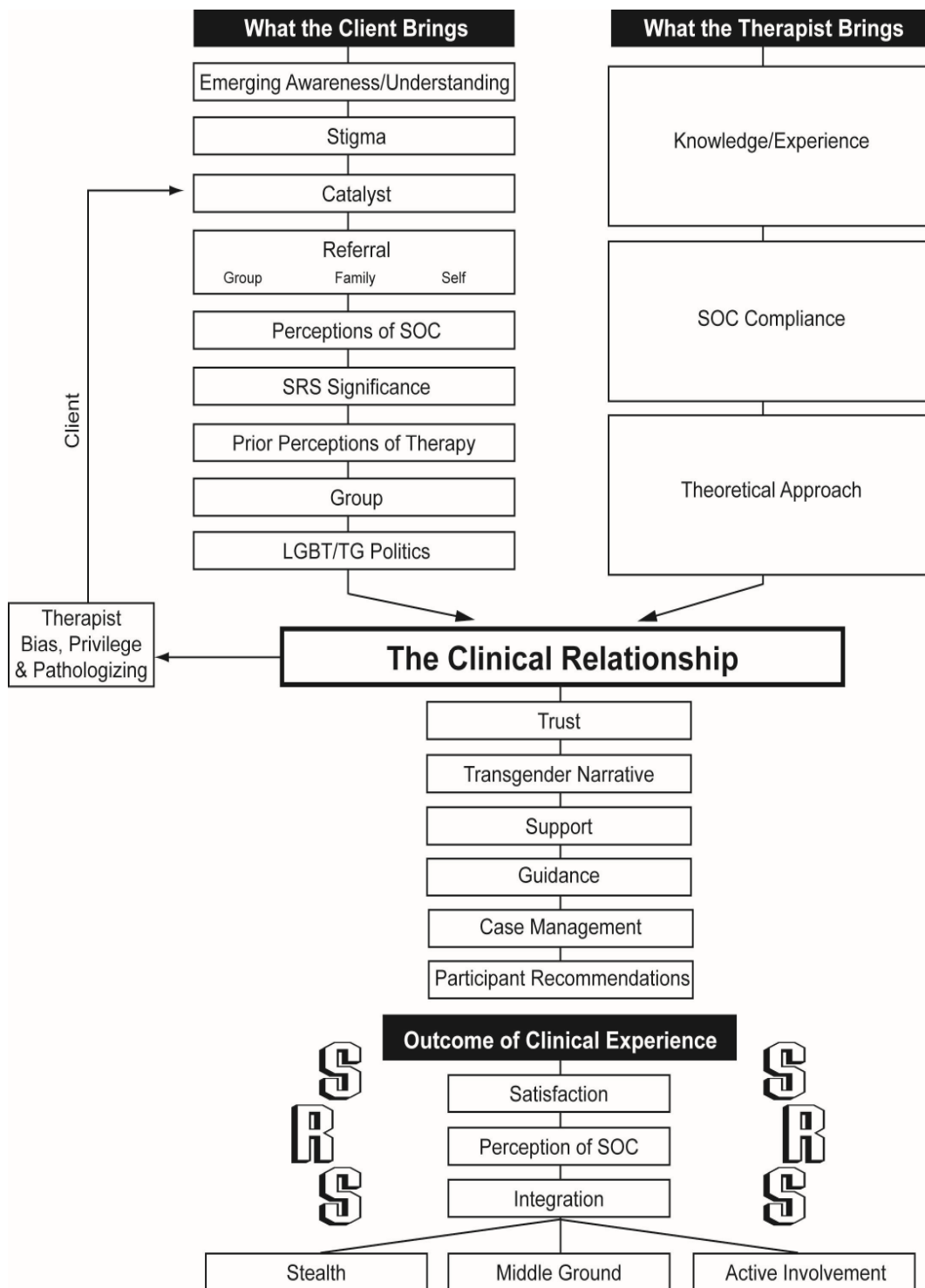
When determining the invariant constituents during the analysis process, Moustakas (1994) suggests that each horizon is evaluated for two factors: does it contain a moment of the experience and can it be labeled. These invariant constituents were then grouped into themes. These core themes represent moments in the process of entering into a clinical relationship for the transsexual client. The final section of this chapter will present the textural and structural composite descriptions, and conclude with the essence of transsexual individuals' experience of a clinical relationship.

This chapter presents the findings of the study, dividing the findings into four core themes (see figure 3):

- What the client brings to the clinical relationship
- What the therapist brings to the clinical relationship
- The clinical relationship

- Outcome of the clinical experience

The four primary themes became clear as the interviews led me to understand that the clinical relationship for participants was affected both by the history and perceptions that the client brought into the clinical relationship as well as the level of competence and experience of the clinician. The participants' perceptions of the standards of care and psychotherapy in general impacted the experience in concert with the perception of transsexual individualism by the clinician. Authors of each quote are indicated by "P" (participant) and a coded number designated for each participant. In the case of answers that are unclear without the researcher's question, "Researcher" is indicated. The chapter concludes with the composite textural and structural descriptions and data that support the statements regarding the essence of the experience.



**Figure 3**

## **I. What the client brings to the clinical relationship**

### **Emerging awareness/understanding of inner gender identity.**

The first step on the road to self-actualization is an awareness of an internal identity. For many participants, they knew that something was different about them, but they did not have the words or affirmation of a transgender identity.

*When I was a young child the idea that there were more than two, that there was any kind of gender variability or that a person would move from one gender, well, it wasn't even talked about, there was no social awareness of it at all, and at the same time, I was very uncomfortable in my gender role without understanding that that's what it was. In other words, I didn't fit in to the prevailing description of a boy, and I knew it, but I didn't know that that was the problem. I didn't know that there could be that kind of a problem. I know that I didn't fit in, and I knew that, you know, it wasn't confusing from the respect that I was confused about my identity - it was confusing in that it didn't fit any pattern that was available to me, there was no model for it. P1*

*I didn't even know what I was. And I don't think I really had any words to describe it. P6*

*The words didn't exist when I was growing up. P9*

The awareness of a female identity felt genuine for some; however, without the social understanding of transsexualism as an option, they felt bewildered and alone:

*I was looking for, basically, understanding, you know- as far as understanding who and what I am and what I was and were there others that really felt like the way I did. P8*

For several of the older participants, the enlightening moment came when they saw a newspaper or magazine article about Christine Jorgensen returning from having SRS overseas.

*I didn't know what it was. It wasn't till maybe when I was in my late twenties - it was the first time I'd ever heard it. When I was eleven and I saw that picture of Christine Jorgensen in the newspaper I knew right...that's when I knew. You know that's it. P5*



And another shared:

*I can recall as a small child standing in the grocery store line with my mother and seeing on the front of some gossip rag, a picture of Christine Jorgensen returning from abroad and the headlines saying, " US GI returns home a woman." And something striking me at that tender age that was of relevance. I related to that story. I identified with that circumstance. I didn't understand at the time why. It was some years later before it all started making sense to me.*  
**P7**

Not only did the breaking published story about Christine Jorgensen help many closeted transsexual individuals develop some clarity about who they are, but it also produced hope that there is a solution to the gender dysphoric feelings:

*I read an article about Christine Jorgensen. I bought a magazine when I was fourteen, it was one of those sort of enlightening moments like, "Oh my God look at this she's done this and she's beautiful and she's managed to somehow do this and so that possibility is real." And that was just amazing to me. Yeah, I didn't have any idea what I would do about it but... good to see that it was there and it was possible as something.* **P3**

Some understood their gender identity, but were not aware that there was anything they could do about their condition or how to go about it.

*I didn't realize that there was any way to do anything about the body that I had. I became aware of the possibility of transition in my teenage years but I didn't I see any way that I could do anything about it.* **P3**

*When deep down I think I always knew. I just didn't want to do what it was going to take to get there.* **P12**

They learned about the possibility not only with the printing of the Christine Jorgensen articles, but one participant found hope when she saw a television show:

*I have some memory of the first time I found out it was possible to change sex... I believe I was watching a TV show, a comedy show or something that made reference to somebody getting a sex change operation as a joke. And, I turned to my mother and said they can do that?! She said yeah, they can do that. It was just extremely exciting for me to find out that they could change sex. I was probably about 8 years old when I found out it was possible.* **P2**

Before information was available in television or the internet, some of the participants described their efforts to learn through the few books and literature available at the time.

*I did a lot of reading. I mean if I had access I would go look things up in the university library. If the university had a med school I could find even more information but that was pretty much it. That was before you could find stuff. There wasn't much out there. There was a little bit of literature here and there but there was no internet. P3*

The advent of the internet provided information and connection to others like them:

*I was a freak. Thank God for the internet. That's all I can say. Because that's where I got my information at first. And I hate computers. So I was really I was never on them. Didn't know a damn thing about them. P4*

Sometimes the enlightenment came from finding online about a support group, or even a serendipitous encounter with another transgender person.

*I had to hide this feeling for a long time until I started to get into touch with the social groups around through the internet. And I learned words like cross dresser, transsexual, transgender and then I started to identify as a transgender person. P11*

*It's hard not to cry when I think about it, because you spend your whole life feeling that you are alone and that there is no one else like you that has your feelings and your issues your whole life and then you meet someone just out of the blue like that, unexpectedly that is just like me. It was a tremendous revelation to me when I found that there was a language, there was a community and there were other people who felt like me. I kind of grew up and lived most of my life feeling extremely alone. I didn't know anyone else like me. I walked out of there that night knowing for the first time in my life that there was someone else out there that was like me. For the first time in my life I wasn't alone in the world and that there was a place and a path for someone like me. P9*

Although social identity develops and changes throughout one's life, inner identity such as sexual orientation is fixed. Inner gender identity awareness has been complicated by lack of information for many transsexual individuals. This section demonstrated with data how many felt clear(er) about their identity after reading

something, hearing/reading about Christine Jorgensen, or meeting a transsexual person in a social setting.

**Stigma driven social identity.**

Use of the word "freak" by several participants is an indicator of the level of shame and stigma associated with the transgender/transsexual identity and gender dysphoric feelings. Although almost none of the participants could articulate how they knew that they should not express their gender identity, they all knew. Before gaining an understanding of their transgender/transsexual identity, several participants only claimed the social identity of "freak."

**Researcher:** *Before you began your transition and therapy process, how did you identify?*

**P4:** *Freak*

*If I identified with my female traits I was going to be a freak, like what I see on television. (sighing) because I had my own prejudices and I had my own, um, just from my own upbringing, the only people that I know, and even when I was a teenager, the only people that I knew that were like me, actually not like me, but were drag-queens, and jokes and freaks. P8*

One participant recalls:

*I don't know, I just know that I always knew that job one was not to ever let anyone know. And I was so proud of myself growing up because I was able to hide it. Although I did get caught a few times that I remember. My sister caught me once.... and she sat me down and said you don't want to be like those people. It will be our secret - again, reinforcing this notion. P12*

The discovery of a social context for a transsexual gender identity and/or the idea that one could change her sex to match her gender identity was not always met with immediate action. In fact, most of the participants kept their new found knowledge to themselves for future reference. After a long period of suppressing and

hiding, these transsexual participants described a catalyst that began their journey on the path to social gender role transition.

### **Catalyst for seeking a clinical relationship.**

Even after clarifying her gender identity, many transsexual adults did not pursue gender confirming processes due to shame and stigma, and a great fear of losses. The suppression of an authentic gender identity expression was possible for a period of time, different for each person, until a personal or interpersonal crisis occurred that forced her to face the issues:

*I had reached a crisis where emotionally it felt like I had been traveling along this path this winding path and it finally came to a place where there was a split in the path and I could not go down the middle any longer, I had to choose to either go back and suppress what was emerging or completely follow through and become my authentic self. So, I went through a period of depression because I was looking at a huge amount of loss if I really completely followed through with being authentic. I hadn't yet, really grasped what I was gaining. P1*

And for other participants, the catalyst was discovering that it was not too late after believing for many years that the opportunity had already passed:

*The triggering event that really started me moving in the direction of transition was when I stumbled onto a website ... a private website for transsexual individuals who kept describing themselves. And there were some transitioned in their 40s and I was absolutely stunned by this. I leapt up out of my chair and started screaming at the computer because I always...how can you transition in your 40s? I had always seen transition as something you do when you're young. And that was very much fixed in my mind this was something you did when you were young, I didn't even know there were people doing this in middle-age. And, so it was something I had just dismissed as, as a missed opportunity that would never be achieved in my youth. P2*

*And then I really felt trapped and believed once you had kids that you couldn't transition. Back in the mid-nineties... And I started drinking a lot. P12*

Although some participants had reached the point where they could no longer tolerate hiding their authentic gender identity, it was the fear that they had to fight - fear based on the stigma and shame placed on a transgender/transsexual identity:

*It was impacting every aspect of my life. And... I basically got more and more thinking that I really need to transition but at the same time, you know, I was fighting it, I was fighting it. It was so, so disruptive in my life and I was so afraid of what people would think. P2*

After deciding to explore the possibility of transition, one option that is available is assistance from support groups and gender centers. It is there that some participants found the support and courage they needed to proceed.

*But the thing that, more than anything else really allows me to really overcome my fear was going to support groups and getting to know other trans people. And, joining them, as a group we'd go out to dinner. That was, I don't know how I could have transitioned if I didn't have the experience of walking into a restroom or restaurant with a group of other transgender people and ordering dinner and having it be Ok. It was a profound experience; it was an extremely difficult experience because I had to overcome my own fear. P2*

Participant 11 was encouraged by her wife to seek help from a support group that could help her with understanding her gender identity.

*I finally told my wife that I need some help, I need some support. And she suggested that I get in touch with other people like myself that feel this way and maybe get on the internet. I did and I found and tried this group in a nearby town. And it wasn't long after that I realized, I'm not a cross dresser. You know, this is still not about the clothes. P11*

And the catalyst for participant 1 was her partner suggesting without prompting that she seek help:

*It was really my partner. She said, "There's something going on with you, we need to figure this out." She knew that I was struggling with my gender identity. P1*

A much younger participant 6 was being guided by her supportive mother, who knew that part of the gender expression exploration and subsequent gender role transition included a series of sessions with a therapist.

*I wasn't aware of a lot of the details on how things worked because my mom was very supportive of everything. So you know she would tell me you know these are your options. What do you want to do? Do you want to start therapy? P6*

Participants described their process of coming out, gender identity clarification and process of coming to terms with the need to transition their gender role and modify their body for gender congruence. Whether through support from family or spouse, or from gender support group or community mentor, it became clear that the next step is to see a therapist.

*Because I knew that was the next step that I needed to go start seeing a therapist. I told my wife and then I said " I wanna go see the transgender therapist." P12*

*The official start of my transition would be a first session with a therapist, because that's where I sort of walk into the institutional process for transition. P2*

For transsexual adults, hiding their authentic female identity was a way of life until a catalyst prompted them to seek intervention. This section presented data that described the experience of feeling compelled to move forward with identity confirmation.

### **Referral - how did they choose a therapist?**

After finding the courage to seek answers regarding their gender crisis, participants looked to therapists to work on these issues. Referrals came from several sources, but primarily participants asked for referrals from people in the gender community who knew about knowledgeable and experienced clinicians.

*I got into contact with a local transgender support group. In that group I could ask, well, who are the therapists in town...People there told me who I could contact. P2*

*It was word of mouth. My mom actually found another teenage girl that had gone through the same thing as myself. This therapist was recommended to the teenage girl from some other people. P6*

*I looked at just the ones that were amongst the people that I knew, because I wanted someone who knew and had treated a lot of people who were transsexual and transgender and had some knowledge about gender identity disorder because I was seeking guidance in this specific area. And, I didn't want to have to educate my therapist. P9*

Some of the gender centers have websites now that list local resources, such as gender knowledgeable/experienced therapists.

*They'd tell me to go online and there's a support group for that. If you're looking for therapist this is the list of all the ones in the area and this is the one I used. So I started looking and I found one; I started going to her. P11*

There is a history of clinicians using the designation of "gender specialist" who were uninformed, misinformed, or maligning in their intent. Therefore, it was of significant help to those who obtained a recommendation from a gender support group or community leader.

*I picked one that everybody at the group said to try. The fear is too that, I don't know if you're aware of this, but...there are therapists out there that try to de-transition you. They're specifically looking, they're biased. There has been one case up in a nearby city where it's a therapist that takes children in and the families think that they're going to get help. But really the therapist is just here to shut that child down from the process. P11*

Sometimes a transsexual individual will contact a physician, seeking hormone therapy to address her gender dysphoria. The physician usually immediately refers the transgender patient to a local gender specialist.

*Through a surgeon's office I found a therapist and she was my therapist for 8 years. P7*

This research project produced an interesting finding; a primary referral source for gender therapists came from electrologists. Some participants sought hair removal first, frequently because they were cross-dressing long before they contacted support groups and therapists. The electrologists often become confidants of their transgender clients, offering a caring ear and a guide to the local resources.

*I had processed it myself before the groups and talking to my electrologist. You know, she was the one that encouraged me to become a therapist. But, she was as close as I had to a really good therapist. She was a big facilitator and supporter of the trans community in my city for a number of years. P1*

*My electrologist recommended a psychologist in the city I was living, so I started seeing her. At the time, my electrologist was a post-op transwoman who was 40 years old and had transitioned as an adult - probably in her thirties. And she was the only person I know that had transitioned that late in life. The electrologist is the one who told me about the psychologist, and then later about the surgeon. P7*

*I started going to electrolysis, and the electrologist pointed me to the therapist ...she suggested it. P4*

After the catalyst that prompted the participant to seek a clinical relationship, they proceeded to seek a referral, primarily to increase the likelihood that they would find someone who had the experience and expertise they wanted. Sources for these referrals came from gender support groups, a transgender mentor, a medical provider, or an electrologist. Because so many participants received their referral for a gender specific clinician from electrologists, it is a significant finding and will be discussed further in the next chapter.

### **Perception of the standards of care and gate-keeping.**

As stated in prior chapters, transsexual individuals who wish to obtain medical interventions such as hormone therapy and surgery are directed by the standards of care to see a therapist for assessment. The standards of care are guidelines produced by a



committee (WPATH) to guide medical service providers and helping profession clinicians in the treatment of transgender patients. However, in the transgender community, it is a cultural perception that it is the transgender patient who is "following the standards of care." It is this cultural perspective that is represented here in this study and the text data being cited.

Because of the cultural understanding and history of transgender care, it is believed by most transgender individuals and service providers that transgender patients are required to see a therapist for their letter of referral for medical treatment.

**Researcher:** *And so why did you go see the therapist?*

**P12:** *Because I was required to.*

The participants were asked about their feelings about the standards of care to help gain understanding of the impact of this gate-keeping mechanism on the clinical relationship and gender transition process.

Some participants were willing to go through with the therapy component of the transition because they felt it was just part of the process.

*I knew I had to see her to get my letters and stuff. P4*

*I was compliant. I figured it's a process like anything else. Its like breast augmentation. You don't just go in ask for them. You got to earn the money. You've got to go through physical checkups. I figured this is what I've got to do for a year then no problem. This is a check list. I'll do one at a time. P11*

*Yeah. I understood that I needed those letters in order for me to get a surgery. So I knew that there was a certain amount of gate-keeper to it. I personally didn't have a problem with it. It scared me a little, but because it seemed like I need their approval for me to get on with my life. P6*

For some participants, there was a fear that they could go to a therapist and have their request for a medical referral denied.

*I was nervous. I felt like this person is going to decide everything. Or if my employer finds out because it was insurance covered. P11*

*I had felt that I had resolved a lot of the struggle internal struggle within me. You know I wasn't going to a therapist to find out if I needed to transition. I knew. Oh yeah. You know I'll be very honest about that, I don't want to be told "no," or "you gotta wait." But I would have been willing to do it. The only thing about the gate-keeping that might have irritated me is that I might have had to wait longer than I think I needed to. I wouldn't have got angry or militant or defiant really... P12*

Several participants described their resentment towards the process:

*Money's a big part of it but there's also that same resentment of having to...why do I need to go get permission from a therapist to have a surgery? The FtMs don't need a letter to have their top surgery. We don't see why we need permission to have our surgery. We're the ones paying for it. And, it didn't make sense to me that there had to be these requirements that I had to wait - I didn't like that. And, he held me very strictly to those requirements. And, I was like, okay, if this is what I need to do, I'll do it, but I'm doing it because it's the requirement that my therapist is placing on me, not because that's how I think things should go. That was very much my attitude at the time. P9*

*Well, I thought who the fuck knows what I need to do. How dare they say that. You know at the very earliest times that I encountered it was just some kind of an imposition or road block. This is something that I know to be true about me. I don't need all this. And there's still an element in me that's rebellious about it in just I'm aware that other people can go get all kinds of other surgeries. I mean you know you can go get a surgery, you can go ask a doctor to make you look like Michael Jackson and you would not have to get a psychiatrist to say that it was ok. I mean you probably should but... I thought wow you know. Why is it this particular thing? Is it because it's those genitals? Is that a cultural value that this is reflective of? P3*

This data passage points to the underlying sexism that permeates the issues surrounding the transsexual community and the process that requires gate-keeping by clinicians.

A few participants even expressed appreciation for this part of the process.

Participant 2 stated:

*I felt safe with her. And I felt, I was fine with the gate-keeping. Actually, I'm approving of the idea of the gate-keeper and was appreciative of the gate-*

*keeper function. I wasn't walking into it thinking this is a burden or a hassle. I didn't have a problem with the standards of care. P2*

This section demonstrated varied perceptions and attitudes towards the standards of care that require transsexual individuals who seek medical interventions to obtain a referral first.

### **SRS significance concerns.**

The serious nature of sex reassignment surgery prompted the standards of care, this in turn drives the involvement of clinicians as gate-keepers. Without SRS, it is possible that gender role transition would not require the services of clinicians. It is the SRS and hormone interventions that are center to the intensity of self-preservation and fear of loss of resolution that many transsexual individuals experience. However, there were participants in this study that expressed concern over the emphasis on SRS as key to gender role transition:

*The standards of care places a heavy emphasis on SRS which tends to be what it's about - which I think kind of perpetuates the image in the mind of the trans community that it's all about surgery. It's all about getting a surgery. And at this point of my life, this period of transition, I just don't see how that is the case. P2*

*Fundamentally, surgery just changes how you pee; too many people go into it looking for way more and they come out of surgery disappointed because the world didn't magically change around them. It has a profound influence on you and takes you three to five years after surgery to realize the influence. There's a lot of transition that goes on in those three to five years between the temples and how your body comes to realize this new physical configuration. Your brain is still changing during that three to five years after that surgery that you can't get to until you have that surgery. P9*

*What I found was a lot of people would put too much emphasis on GRS as the defining piece of the transition. And you know somebody asked me if I had it and I said "Oh, you mean the plumbing remodel" - and it was more accurate than anything else. Cause, you know my sense of myself didn't change with that in anyway shape or form. Whether it was a sense of myself or my sense of my gender or whatever it didn't change. All it did change was my plumbing*

*changed. And yeah, that's nice and is good and I find that I feel better after about myself as a result of that, but it's not the be all end all of transition. And it certainly didn't change my identity. And when I was going for surgery I met some people there who said "this is my life's dream" and I said, "What? Sitting down to pee is your life's dream?" P3*

*There are an awful lot of people who just say once you get that surgery then it's 100 percent, I'm completely a woman. And to me, when I hear people say that, I'm thinking they've got to be kidding themselves, they've got to be deluding themselves, they've just got to be convincing themselves. Either that or they're using SRS as status symbol in the community to say that I'm better than you. I think that by going full time and learning how to relate to the world in the female role and present yourself as female - that is the real transition. That's far more important in that SRS is a surgical procedure which is available to transsexuals to help them feel more comfortable in their transition. But I really think it's a falsehood to say that that one thing defines the transition. P2*

The standards of care provide guidance for the care of transsexual women and men who seek medical intervention. Some participants expressed concern that many transsexual women place too much emphasis on the surgical procedures rather than the gender role transition. The development of the standards of care appears to some to reinforce this idea that genital surgery is protected due to societal sexist attitudes.

### **Prior perception of psychotherapy.**

Because a clinical relationship is a requirement for most transsexual individuals, it is possible that clients frequently are in a position with a clinician where there is additional shame or angst due to prior perceptions of psychotherapy.

*Oh, yeah, you know... crazy people and rich people go to therapists, you know that kind of thing. My need was greater than my fear. P7*

*I didn't have the best view of therapy and therapists and I was pretty alone during that time in my life too, and, and lonely - I isolated myself, emotionally, physically. Back then I was actually fairly judgmental about therapists in general and I didn't really like a lot of ideas from therapy because of my own stereotyped ideas I had about therapists. I felt that I had too many friends who were way too caught up in their heads, blaming the world for their ills and*

*their problems, and, the therapists getting 'em too focused on the negative stuff in your life. P8*

There were also positive perceptions of therapy, and the expectation that therapy would be helpful in the gender exploration and transition process.

*I really personally wish that my therapist had been kind of tougher on me. I wish that she had taken a more assertive approach, a more challenging approach. Because this is serious stuff. I'm not one who is going there because the process demanded it and, and just say, "Well I need someone to write my letters and then I'm going to get out of here." I'd say that part of the process was something I was actually looking forward to. P2*

*I was very anxious and I had a lot of trouble finding myself and fitting in, and I had a lot of insecurities. The counseling really helped me deal with that stuff and help me deal with life - you know, on going life issues. P6*

#### **Group.**

Most of the participants described their experiences with gender support groups.

This activity is generally seen as a suggested activity in conjunction with individual clinical sessions. What was interesting were the participants' smiles and enthusiasm as they shared their experiences and the impact of group on their transition:

*Clinical experience? I think in many respects in terms in the aid of transition I think the support group experience is really more valuable, at least it was for me, than the sessions with the therapist. I got into the transgender community and started meeting other transsexuals, which is an enormously eye-opening experience - making the types of connections with other people going through it, and getting tips in advance of what was necessary before going through it. Therapist have their role and their purpose, but the value of support groups should never be underestimated. P2*

*I thought I was the only person like me, you know. Little did I know that I had been transitioning, for years before I even went to a group, and felt like I was one of the only ones around. Then I was like, wow, there are other people! So I started going to group initially for information and what not, and then also to meet others and like-minded. God, I was excited and I honestly had no idea because I hadn't knowingly run into people like me. I just really hadn't a clue, cause I felt like I was the only one there at the time. It was really exciting and it was actually a pretty fun time, and scary too. P8*

*They helped me see that I wasn't a freak, and that this was a very much recognized condition of gender variance - I wasn't alone in this feeling. And that what made me feel good about it was that they were giving me ways of how I could implement this into my life slowly. P11*

Not all group experiences were positive. The following excerpts of data indicate the power of groups - for positive outcomes or harmful ones. The first example comes from a participant who entered a group who perceived her to be out of the stereotype of what is expected of a transsexual individual. Their rejection caused great harm and delayed her transition for many, many years:

*Yeah. I didn't feel at all welcome there. And I was pretty shy and sensitive at that time. You know, I couldn't speak openly about stuff, I didn't know who I could speak openly to - certainly not anybody in my family. So I thought it was a pretty gutsy move to go to those folks and... to then get rebuffed was more than I could deal with at the time. That put a lot of doubt in my mind - "well ok, maybe I'm not..." cause these are people who are supposed to know and they didn't think I was so maybe I'm not authentic - I don't know. P3*

Another example of a painful rejection was shared by participant 7, due to her status as one who lived stealth and now has come out many years past her transition:

*I've had e-mails come to me after attending a gender queer or transgender group meeting asking me not to come back because I don't fit in with the main-stream of the group. Because I am many years post-op. P7*

Participant 9 shared her concern over a common theme of negativity in many support groups:

*This particular group is rife with the "woe is me" kind of support group. And you go in there and listen to sob stories and you know you can go back 2, 3, 5 years later and it seems like you're hearing the exact same stories over and over again; it never changes. And that just wasn't for me because, I wasn't "Oh how terrible is my life" in need of a support group or in need of a therapist. I was a person of action. P9*

Participants described, with intensity of emotions, the benefits of attending gender support groups. There are support groups in several major metropolitan areas

of the US. This kind of support group carries great influence over the recovery from stigma-related shame and the sense of hopelessness that harms clients when they feel isolated or alone in their gender variant identity. Also, participants shared cautions for the power of groups who reject an individual's claimed identity or perpetuate the hopelessness within a group culture of negativity.

### **LGBT/TG Politics.**

In the quest for equality and access to appropriate medical care, the transgender community often gets side-lined by identity politics. A few participants shared their concerns:

*We don't really live in a world where we're judged as individuals. As transfolk, we are judged as a society, as a group. This is why hate crimes are affected against us, this is why we become social outcasts, this is why we do seek out community together - because the world groups us that way. Even within the LGBT community, they really don't want us either. You know...the gays and lesbians would just like to kick us out from underneath the umbrella, they don't care about the bias because they never show up. P7*

*Pretty much, yeah, and the women, the lesbian community here all know, I'm out to them - they know I'm trans. There was one situation - they started a born women discussion group and I was not invited to that. And I totally get that, and it hurt at the same time. I understood, but I mean, it was still hurtful. I totally get the thing about women's space, and I also get that, you know, when a person totally and completely identifies as a woman it's very hurtful to be told that you can't come because you're not a real woman - you weren't born that way. P1*

Even more concerning to a couple of participants is the in-group identity politics:

*Are they politically motivated, non-politically involved? I mean there's a great deal of separation within this subset of a culture. P7*

*Something I would see in these groups a lot is this real division, justification of who they are by masculine traits and feminine traits, and people identifying only with these feminine traits, and all the masculine traits are bad and wrong, - and you shouldn't identify with those. P8*

Identity politics are relevant to what the client brings to the clinical relationship. Transsexual individuals are a marginalized and vulnerable population. They are also additionally marginalized among their own segment of the population. Feeling insecure among people that they perceived to be their peers added additional stress and lowered self-esteem. This is often learned in community settings and affects the clients as they enter into a clinical setting where they already feel a power differential.

## **II. What the therapist brings to the clinical relationship**

### **Level of knowledge and experience.**

Transsexual individuals are a vulnerable population who rely on the expertise and guidance of clinicians charged with providing letters of recommendation for medical interventions. When clinicians are uninformed or misinformed, participants were harmed, some with serious repercussions and trauma. When the clinicians are educated and experienced in transgender care, the participants report a much more positive outcome of the experience.

*Well, the first therapist I went to, which was the very beginning of understanding that I was dealing with my own gender, was not a good experience. I went to a therapist who supposedly specialized in transgender issues and I told her my story, you know, like childhood development and when I came to understand that my identity didn't match my physiology and she said, "Well, that doesn't sound transgender, that sounds like an effeminate gay man." And, the session was over at that point. She just didn't get it and she was supposedly a specialist! She was like the best we could find at the time in the city I was living. P1*

This participant went on to describe her relationship with a subsequent therapist who was knowledgeable about transgender issues:



*I was fortunate that the therapist that I was seeing through a lot of my emotional transition is a transsexual; he's a female-to-male. And, I felt so fortunate to have a therapist who had been through the process himself. P1*

Another participant shared her painful story of being rejected by a therapist who harmed her so significantly that she did not return to her need to transition for decades:

*I said, "I think I'm transsexual and I would like to start on hormones." He looked at me sort of perplexed cause I wasn't presenting as female and so he said "what makes you think so?" and I said, "well it's just my sense of who I am." And he said "well..." and he asked me some questions and I think he asked me questions about my orientation and I said mostly I like women. And that was definitely one of those things that said "no." He asked me how I sort of envisioned my future and that got kind of squishy cause I was thinking... already thinking about moving to San Francisco and...and you know. "You wanna get married?" No.*

**Researcher:** *How long was that first visit with that doctor?*

**P3:** *Not long. Not long. Probably twenty minutes.*

*No, I didn't go back. I was really scared and pretty awkward about it. It was a very frightening thing for me to do. It was really frightening for me to acknowledge that about myself. And it was even more frightening to share it with anybody. You know in those days at that time you know people were pretty rare. It was not a common thing and I didn't know how to voice my feelings and how to articulate what I really wanted. I was pretty um... and your doctors - he was this huge authority figure that knew everything.*

**Researcher:** *So what happened? When did you start the actual transition process?*

**P3:** *Oh not for many years ... thirty years later maybe.*

Yet another participant described a very unsuccessful therapy experience with a clinician she saw. She had hoped that the therapist could help her with issues in her marriage that came up while she worked towards gender role transition. By her description, it appears that the clinician's skills were not suited for working with someone experiencing stigma and shame about being transgender. The lack of clinical skills kept her extremely reserved in therapy:

*Yeah, well this particular therapist was not the right person to see. He was a sex therapist actually. When I went to see him I and even thought I knew he knew what was going on and I sat down and he says, " So tell me what's been going on." It took me a good two sessions, I couldn't speak. And he finally*

*had to start pulling stuff out of me. With just talking and stuff was therapeutic and then my wife started going along with me and he was a sex therapist so he started talking to us how to get our sex life instead of focusing on my gender issues. P12*

One participant described an adequate clinical experience, but she had words of advice for clinicians who diagnose gender conflict:

*When you're in the psychological profession I think you're very much afraid of influencing results if you tell the patient certain things, but those of us in the gender identity area are in a unique situation. Our diagnoses is not determined by the psychologist, it's determined by ourselves. We are self-diagnosing, there's no set of tests you can give us, there's no telling for sure, this person's a transsexual, this person's transsexual, this person is, um, a cross-dresser. There is no defined way to do those things, we have to be self-diagnosing. P9*

Transgender care is a highly specialized professional practice that the participants needed. The participants preferred to receive services from experienced and knowledgeable clinicians. Those who did reported satisfaction with the experience.

#### **SOC compliance of the clinician.**

A factor that participants described as having an impact on their clinical relationship was the degree to which their therapist perceived what the standards of care required, for example rigid compliance. Some clinicians were flexible but still had resentments against them about gate-keeping in general:

*I wasn't worried because I was already on hormones. And I think I already knew that the whole gate-keeping thing had eased up a lot. Actually this particular therapist had a run in and had some bad press on the internet from some people who didn't like gate-keeping, but it wasn't true. P12*

Participant 8 described both her frustration with the imposed requirements, yet also a conviction that if things did not go well, she would seek another therapist who had more reasonable requirements:

**Researcher:** *Are you opposed to the standards of care across the board?*

**P8:** *Yeah, I am. And I was told at group that no one would write me a letter without seeing me a minimum of twelve times or three months, and I was given that rigmarole and I was like (sighing). You know, I was like - great. Well no, I really wasn't worried, because if that person wasn't going to write me a letter, because I guess I was pretty confident and happy with how things were going and who I was. If they wouldn't, then I would just go to . . . try to find somebody else who would.*

After learning about the standards of care and working through her frustrations,

participant 8 was able to find and pre-screen a therapist she felt comfortable with:

*Well, I was concerned yes, yeah. I would have to say, but that even through speaking with her on the phone before I saw her, her willingness to work with me let me know that it was probably going to be okay. P8*

Participant 12 also found a therapist who had a flexible application of the standards of care guidelines:

*I mean I already knew her. I knew her from going to - she came to the social events that our support group would have. That and I knew some local girls, a girl from another nearby town that had just had her surgery and was telling me to go see her and...and she'll be able to help. And I knew people several people actually that transitioned that were patients of hers. And they talked very highly of her. And I was very please that I wasn't gonna have to do one year of a real life test. And I get that. I understand it. To me it's just like they picked one year I mean why twelve months why not thirteen months or nine months. It's like someone came up with the year, it's a pretty good time. It's a long time. P12*

Participant 9 appreciated some aspects of her clinical experience, but expressed

frustration with her therapist over his stringent perceptions of requirements:

*And, I started hammering on my therapist - hey, can I get my letter. And he was like, "well I usually take six weeks from the time we start" you know, this kind of thing. He had his time lines kind of set up, and so I, being the intelligent, inflexible person, it was not what I wanted - it was a hurdle I had to jump. I had to see him weekly for six weeks from the time we started specifically, counseling with regards to gender. He wouldn't even count the sessions that I had with my ex together. I was going to meet that requirement and get to the hormones as quickly as I could. I resented a lot of part of the requirements associated with the whole procedure. P9*

Participant 9 described her experience with following the standards of care; however, as a leader she has also met and mentored many transsexuals who have found a way around the system:

*I've talked to literally hundreds of girls that are younger, that are in their twenties that are out there, that don't want to go through the therapy; they know what they need, they want to go around the system. They're buying hormones on the black market, they're doing their surgeries in Thailand. I'm helping them, I'm teaching them what they need to do to do surgery in Thailand. How to get their visas, how to get their passports, how to get their visas, who the surgeons are, how to pick their surgeon, what the difference is between the different surgical procedures that the different surgeons use. I'm out there, I'm helping them because I understand; they aren't getting help. This is the kind of help the profession should be providing and it's not. And some of us in the community have to do that. P9*

The standards of care were created as guidelines for clinicians who work with transsexual and transgender clients. Participants shared their experiences with therapists who implemented differing levels of compliance with the standards of care recommendations. The above quotes indicate that clinicians who were flexible in their application of the standards of care were viewed as more user friendly for clients, making the experience a positive one. Clinicians who held strict interpretation of the standards of care were perceived by participants as too focused on gate-keeping and rules for the sake of rules.

#### **Clinician's theoretical approach to practice and gender variance.**

Even more important than the SOC compliance is the clinician's perception of gender and the paradigm or theoretical approach they use to work with transgender clients. Because the understanding and treatment recommendations are still evolving, there are clinicians with varied perspectives on how to comply with their role as clinician and gate-keeper.

Participant 3 described her therapist in a positive light:

*She wasn't in any way questioning that and I think that sort of the gentle easy understanding was probably what worked best. P3*

But this positive experience was long after a very negative experience with a clinician who made judgments and assumptions based on older theories and paradigms. "Older models" as stated in the participant data below refers to a paradigm and perception of gender variance as psychopathology, of clients who needed labeling and directives to lead their lives, and of the perception by the clinician that they are the best judge of who should be "approved" for medical and social role transition:

*Well you know, I wasn't dressed as a female. I wasn't trying to live as a female at that point. And I wasn't able to articulate that I wanted to be sort of a fifties house wife. Which was, it seemed the model that was expected of people. I later learned from other trans people you know that they often would rehearse the proper responses to questions that the gender clinics were uh asking in those days so they would be given permission to go through the transition. You know, he talked to me briefly and didn't think I was appropriate so he wasn't going to start me on any kind of hormones. Some of the university medical schools had a pretty narrow ridged prospective on who was appropriate for transition. P3*

This participant explained that she was not alone, that she has met and counseled other transsexual individuals who have had similar experiences:

*They maybe run into someone who's operating on that old model. You know they get shut down. And the provider may know the very old earlier models and that's not uncommon. I have found providers around that are familiar with the standards but aren't familiar that they've been revised a few times since. P3*

Participant 9 offers her understanding of this problem:

*But, the problem is we're using a one size fits all model with our therapy and if you don't fit the one size fits all model, which almost none of us do. As a matter of fact, the one group that fits one size fits all model the best are those who are 45 and older when they start transition. That's the one size fits all. And so that means most of the people that are transitioning nowadays are struggling with the therapy models. P9*

The clinician's perceptions, paradigms, and approaches are varied and can be troublesome in these situations. However, the general rule of human nature, that we all have biases based on our personal experiences can be detrimental, especially to a vulnerable and marginalized client:

*The first things she said was do you think trans people are narcissistic? My wife said "yeah I do" and she said "I do too." I wasn't in the room, my wife told me this later. She said "I used to be a therapist for overweight women. I found out that overweight women tend to have husbands who are homosexual or gender variant of some kind." So she had a major bias in there. P11*

The data demonstrates the risks and benefits of clinicians' personal bias and privileged perceptions of marginalized clients. Those clinicians who appear to pathologize difference are seen to cause offense and harm to the clients they purport to help.

### **III. The clinical relationship**

#### **Trust.**

The transgender/transsexual identity comes with a social price - stigma and oppression. The stigma and oppression in turn generate and reinforce a low self-esteem and insecurity for transsexual clients. This insecurity is further reinforced by the power differential in the clinical relationship. Due to the possibility of therapists rejecting transsexual client referrals for needed medical care, the clients enter into the relationship with great fear, as well as a need for self-preservation. Thus, developing trust is important.

Some participants reported feeling at ease with their therapist, building a functioning level of trust:

*I did want to see if there were things I needed to work through. And we were talking just like I would talk to one of my friends you know like what we do*

*here at the conference. We have all these conversations. Things about being trans. That's all we did. It wasn't like we were delving into was this right or wrong for me. I really liked going to see her. Because she...she really connected with me. P12*

*I had a lot of support from my mom and you know, my therapists weren't mean to me - they weren't degrading. Just going through the therapy I think I just become aware that I am gonna get what I want. And my therapist just being there for me and talking to me and just being so nice . . . P6*

*She's okay with the standards of care. One of the things that she talks about is some flexibility about some stuff too. And that the standards have some flexibility in them. P3*

An impediment to a successful clinical relationship was when the therapists' role as an expert was used to label their clients' identity for them rather than allowing time to process and hear how the client perceives her identity. An authoritative label or diagnosis based on bias and misinformation caused harm in these clinical relationships, as well as harm to the clients' overall well-being:

*Yeah, she was just, you know, she was labeling me inaccurately, based on the half hour story I had to tell her, she had come to a conclusion about what my identity was. Yeah, she told me what I was, so she labeled me, this is your identity, and, yeah, she didn't do that in a really intense, heavy-handed way. She said, "it sounds to me like you're not this, your this", but what I heard in that was that she was making assumptions based on stereotypes that she'd already formed in her mind, you know, that's what I heard. She was making an assessment, telling me something about, something that was a very serious matter after not having really knowing me very long. It didn't come from me, it came from her. She was being an expert, you see what I mean? P1*

This participant had the gratifying experience of running into this therapist several years later and having the clinician admit that she had been wrong:

*She walks up and I say, "Hi, how you doing." And she looks at me and she recognizes me. She says, "Boy did I get that one wrong." She said, "You know I really, I called it wrong." To me, it was like, I just felt that what she had said was unprofessional - it gave me model of what not to do as a therapist. P1*

For the participants who were primarily interested in obtaining a referral letter for hormones and surgery, the anxiety and distrust was intense:

*When I was twenty, kinda difficult - there's an element of oh crap what if she says no? What if I get rejected? What if ...what would I do? So that feeling, whether it was rational or not was still there in me. Cause it had already happened. You know... Yeah...yeah I fear to talk about it. I was really nervous talking about it. I was very scared. You know cause I just didn't have the understanding and so I was scared and I was scared that I would be told no. And it's a sense they might say no to who I am. Its not only no, I'm not going to give you these prescriptions, they'd say no you are not who you are. P3*

*You know them telling me no you can't do this, or maybe tell me something I don't want to hear like, "you know you'll have to wait" or "it's not possible" - things like that. That was more my fear then anything else. I wanted this so bad and I don't want anybody to tell me that I can't have this. And I knew that I had some sense but I needed those therapists for that reason. So I think it was only natural for me to have some anxiety for the counselors to say no, you're not the right candidate. It was defiantly anxiety. P6*

*It was not an a relationship where I was open to my therapist. It was a mess. I was managing him to make sure that I got the letter on time and I delivered to him little mile stones all the way along the way that made it look like...made sure that his expectations, his understanding of where I was; and that I was making steady sure progress towards being the perfect ideal candidate for GRS; and that would be happy to deliver me my GRS letter on the timeline that I needed it to be - which was as fast after the one year requirement as I could get. It was a matter of taking the elements of my life and fitting them into a plausible narrative that managed his expectations to my ends. P9*

**Researcher:** Did you tell him any untruths or exaggerate anything?

**P9:** No. I filtered.

### **Transgender narrative.**

An important legacy still enacted in the clinical relationship is that of the transgender narrative. This is a list of criteria that has long been outdated, but still used by some clinicians and used as legend in transgender communities. The narrative is learned and passed on in transgender circles in order to ensure that they receive the medical care they need. Contemporary clinicians do not follow these old narratives, but



many transsexual individuals still use them because their mentors had the experience of needing them.

*Well, I guess when I first found out about it years ago I was a little irritated, and I was, I was worried. What if I ever seek therapy and they tell me I'm not...you know. And am I gonna have to say the right things? Because I grew up being a person learning how to say what people wanted to hear to please people. I couldn't be honest about who I was so I think naturally spilled over. If I go to a therapist can I be honest? So the standards of care I...I guess to me created a little barrier to - wow, I want to be honest but I surely don't want to say that one thing that's gonna put the brakes on for me. P12*

*I was told "no" because I didn't have this or that part of my history that all true transsexual individuals have to have. I didn't have the memorized narrative - and I still refuse to use a memorized narrative! And yeah, so I didn't have to say, well at this age I was putting these clothes on, and then I did this, and so when she didn't hear that from me, then she said "well you must not be transsexual individual because all transsexual individuals do this and then they do this and then they do this." Right? Wrong. (Laughing) Each individual is different. P1*

*What I said wasn't right. It didn't . . . it didn't fit. And in those days it was a pretty narrow little definition that you had to fit within. You had to be heterosexual, you had to kinda wanna have the ideal, you know, suburban housewife kind of lifestyle - and be able to kinda articulate that. And I . . . I wasn't there. I was already a hippy at that point so that was another strike against me. There's just something that's fucked up about that. Pardon my language, but it is just fucked up you know. And even when I started going to the support groups in another city people were still rehearsing those old lines - because they thought they would still need to do that. And people would talk about the you know you go to see the doctor you need to say this and you need to say that. Yeah, that was one of the places they learned it. P3*

While some participants expressed fear, anxiety, and anger about the standards of care and required narrative, many expressed a determination and demonstrated their sense of self-preservation:

*I remember just being very anxious, knowing that could happen - them not approving me or not giving me my letter. I think I was gonna tell him anything he wanted to know in order to get hormones. P6*

*I had known enough and read enough on the internet to know about the Benjamin Standards. I knew about the Benjamin standards before I started*

*going to the group and knew about people requiring three months of therapy and what not. I knew about that stuff, and it was just like, great, and I read accounts of people. What's to stop any patient from just telling the therapist whatever it is that they want? And I was prepared, if I had to see a therapist, and I had to go for three months, I'd tell them whatever, whatever it was I felt that they needed to hear. P8*

Participant 9 described the nuances of managing and interpreting the apparent approval or disapproval of responses to her therapist's inquiry:

*You're absolutely terrified that you're not going to get that letter if you don't manage those expectations absolutely perfectly. And you have to, you know, ...after you've worked with a therapist a little while you start to understand ... people inherently react with body language, approval body language to certain things and you start to see what things they approve of - how they, you know, when you make strides. And so, you start feeding them those little mile stones of passing in society. Every time you find one of those you feed that to them. There were some discussions that I started, he would take a little too much interest in and I would go oh, I think this is going in a bad direction. I could tell from his body language and I'd have to steer away from some area, and then just try and never go back to that again. P9*

There are clinicians who are aware of the use of the rehearsed transgender narrative and work to assure the client that it is no longer relevant.

*You're right. I had a reservation for awhile. Like, if didn't say the right thing I wouldn't get what I wanted. In the beginning, yeah - I didn't tell them about wearing my sister's clothes and masturbating as a child. I thought it was like, weird. They started to make me feel more comfortable with sharing, kind of like you're doing now. It was a slow process of disarming and making me feel comfortable. They made me feel that they weren't going to take anything away from me. That I need to come to terms with and say these things out loud. I needed to be ok with these things. Until then, that was something that eluded me. P11*

The transgender narrative is part of the transsexual legacy of old beliefs about selection criteria for surgical intervention. The narrative in this context refers to the memorized life story that some transsexual individuals learn to ensure approval and referral for medical intervention.

### **Support and affirmative listening.**

Several participants shared their experience with supportive and affirming clinicians who were better at listening and easing anxiety about the process:

*She was just you know really reaffirming with me about who I was and easy about it and not judgmental and you know kinda pretty quickly got that I was authentically what I said I was. P3*

*The main therapist was just very laid back. He was just very relaxed - let me do a lot of the talking and so I think him being just relaxed was reassuring to me. You know, kinda letting me discover and me talk about what I'm going through and stuff like that. He didn't do a lot of you know, "Are you sure this is the right decision?" He'd tell me my progress, say "I think you're adjusting very well," and "I think this anxiety or insecurity that you're having is pretty normal." You know, just very reassuring. He seemed very positive. P6*

Therapists who are active in the transgender community and have a favorable reputation provide a more positive impression of the clinical process:

*I knew that this would be different. I knew her from all my years in the local community, and she's got a great reputation - I think the world of her. P12*

Some gender specialists run groups for the transgender community, again improving trust between gender specialists/therapists and the transgender community.

*My therapist is a very morally and...and personally supportive. She is a great as being a cheerleader of, being very encouraging about being out and trying to gain experience. And she's very good about being supportive of the community. She runs a support group. I think it's really great that she is encouraging of people to connect with other people who are going through the same experience. Yeah, that definitely meant that she cared more. I got a very strong impression that she definitely cares about people in the community. P2*

*The therapists who ran the group echoed, and I found them telling other people in the group the exact same thing that I was thinking, that would be along the lines of identifying, you know, being realistic about your goals, realistic about what you're trying to do, or being patient and not being black and white about things. So, being a little more...they were the most practical minded therapists that I had run into. P8*

Clinicians who are positive, supportive, and practice good listening skills provide the best clinical atmosphere to encourage mutual trust and growth in the clinical relationship.

### **Guidance.**

An important therapeutic goal for some of the participants was to receive assistance in understanding, clarifying, and affirming their gender identity.

*I was very focused on finding things out and finding out about me and finding out where I needed to be. His insights were actually quite useful to me, and he was very good at guiding me on some things. His goal was to lead me to help me identify where I fit in...in the gender spectrum. P9*

*I was looking for information and trying to sort myself out. Exactly what's this about - I'm having these feelings of, this emerging stuff is coming out. I'm beginning to learn about myself, what does it mean? P1*

**Researcher:** *What was the goal of seeing the therapist?*

**P5:** *To find out what's going on. I wondered why do I like dressing in female clothing even though I'd seen that picture of Christine Jorgensen. I mean I hadn't really given it much thought how far I was gonna go. I say there's a lot of us still don't understand until there's one point in their life you just go...okay now I understand I've gotta begin this process.*

*Hi job was basically convincing me that I'm not a freak. Because, I literally thought I was alone - that I was unique, the only one, even though I knew about Renee Richards and Christine Jorgensen. P4*

During the coming out process, several participants described an internal conflict - hoping that the clinician will make "it" go away, and, conversely, that the clinician will affirm the female identity they genuinely know to be true:

*And so, starting up therapy I was, you know, it's an enormous conflict. There's a part of me was pushing me forward in that direction because I'd wanted it all of my life and it seemed like it might be within my grasp but I have contacts and people know how its done. And I'm getting really depressed about not doing this. At the same time I still have an enormous irrational fear of having people know my deep secret. The entire process, I kept moving deeper and deeper into my fear but I couldn't stop and go back either. P2*

*When I started seeing him it was to help me get rid of these desires - this inner urge there's something wrong with me. P4*

*Yeah, give me a pill or something. Make it go away. Or maybe it was Jesus or something - I went to my pastor. Maybe I just have the devil in me, I don't know. P11*

*When I was trying to convince myself this is just a fetish, this is just a clothing thing you know, this is just fun on the weekends, this is just expressing another side of me - that's what my wife was kind of led to believe. I was trying to convince myself that I was just a cross dresser - when deep down I think I always knew. I just didn't want to do what it was going to take to get there. P12*

*I was worried about that. I mean at some level I think it was a fear of it being more real in some way too. It was just definitely each of those steps. Whether it's talking to the doctor or coming out, talking to therapists, going to group. Each of those steps makes it more real. And well, it's both exciting and it's also scary. P3*

*If you could sit there and say, "okay I'm gonna snap my fingers and return everything to the way it was and you won't want to be a girl. You'll be happy being the man and grandpa. Or, you can stay like you are." It would really be a hard decision for me because I like me in my genuine female role. P4*

Clients who seek assistance from gender specialist clinicians come for different reasons. Some desire help with understanding their gender variance. Others come with a clear agenda to receive a letter of recommendation for hormones and surgery. Yet others seek guidance and case management for the gender role transition.

### **Case management.**

Different from traditional psychotherapy, the gender specialist clinician is often called on to assist the transsexual client with case management.

*Yeah he was doing a lot of case management and let me put it this way - I've learned a ton more about the path and the things you go through. P9*

*I remember a therapist telling me this is the road, this is what you're going to do. P6*

*By the time I left the city I was living in at the time, I had a pretty good idea that it was an option for me. And so it wasn't that the work I was doing with my therapist was focused on what do I need to do in order to impress him to write the letter at all, it was what do I need to do to be prepared for this transition from male to female. P1*

Case management often included social management for those who lost their support network while transitioning:

*It was mostly to help me deal with my losses because when I was working I was a high level supervisor. So, I lost all my old friends. They won't speak to me - I've talked to them. Guys I grew up with. P4*

Case management for work with transsexual individual clients can range from assistance with managing employment issues, to relationship issues, to social understanding of gender role transition.

#### **Participant recommendations.**

This study was created out the desire to learn about transsexual individual women's experience of a clinical relationship by giving them the voice to speak for themselves. Participants were asked the direct questions of, "What would you like to see done differently in this process?" "What did your therapist do right?" "What could be done better?" The answers to these questions along with some additional comments are shared below.

#### ***Gate-keeping.***

Participants describe their feelings about the application and interpretation of the standards of care by clinicians, believing that more flexibility is needed:

*And you have people who live for years in their gender that is really them before they want to do some of the stages of transition and it's silly to hold them by the same standards as somebody who's brand new to it. P3*

*I think that the current standard is too lax for some people, where as other people probably do quite well on the current standards. P7*

*I guess I'd like to see things to be a little more flexible for therapists and not have their hands tied. It is getting better, but a lot of the times, their hands are tied, or because they want to tie them, but just through lack of knowledge. P8*

There were a few participants who believe that the standards and gate-keepers have not been stringent enough:

*I think that there are plenty of reasons that people would want to transition that are questionable in their validity. P2*

*The system right now is not filtering out some people that it should be filtering out. P9*

Several participants expressed concern for transgender individuals they have met who they believe to be struggling. The participants stated that they believe some may have passed through the assessment process when maybe they should have been screened more thoroughly.

***Therapists need more education and training.***

A primary concern expressed by all participants is the need to train clinicians for work with the transgender community.

*An experienced therapist would be wonderful. Ones that come out of their college trained specifically and interned for a long time before they're left alone to take on those types of patients. Because gender variance rides the coat tails of the gay community which I have an issue with. This is something that needs to have its own designation. P11*

*I think if people see a therapist and the therapist knows what they're doing and understands something about what all of the complexities and the dynamics and the stages and all of the things that people can go through might be about I think it's valuable. You know, where it's frustrating is when people see somebody and they pick somebody out of a book because they have insurance and well they don't know.... and I still hear those stories and it's especially A lot of times they'll go some place and a person will say well I don't really know about that but what can you tell me. P3*

***Listen/don't label.***

As shared earlier, a few participants described their experience with clinicians who incorrectly labeled them as something other than their authentic gender identity. It was frustrating, and to one participant devastating. The advice given by participants was that clinicians need to "listen, don't label":

*You know, all I can say is listen. I just think that's really the key is listen, you know. What the person brings to the first session is not necessarily what ultimately you work on, but at the same time that's what they need to talk about right then, you know and maybe it takes three months to really get in to the core issues, and yet what a person brings to the first session is their immediate concerns so, hear them, is all I can say. Without judgment. And also, really understand that if they are in a relationship, their partner is going through a transition too. P1*

As spoken by this participant, good listening skills are key to supporting that client, as well as building trust to do the work ahead.

***Expand gender variance taxonomy.***

Some participants expressed varied views on identity politics, but when asked about social work with the transgender community, they requested more flexibility in presenting gender identity options. One participant expressed the need for more attention and care for transsexual individuals who lived a stealth life from times past when that was necessary for self-preservation. They are emerging again as transitioned transsexual individuals and need support:

*I'd like to see people at all stages and even people such as myself that have emerged from a life of stealth that are learning to deal with living an authentic life, it's not easy and we need support. It is another transition. And, for me, at this age, emerging from stealth was a great deal more frightening than my initial transition when I was young and brave and careless. P7*



***Additional recommendations for service providers.***

Several participants made additional recommendations for service providers and the helping professions regarding assistance and guidance with the transgender community. Participants expressed appreciation for providers who took a more active role in the transgender community outside individual work:

*She gets connected and involve in the community. She doesn't necessarily only see people in her office and that's it. She's more interested in things going on in this community at large. P2*

This participant demonstrates the healing power of building bridges in a cooperative effort to improve society's perception of transgender individuals.

One participant had strong words for suggesting more required guidance for those following the Real Life Test (aka Real Life Experience) when those transitioning are required to live in their target gender role for 1-2 years. She expresses concern that there is not enough "training" for those who wish to comply with society's expectations of female behavior:

*We call it a real life test and you know it's used as a test by the psychological community as some kind of proof of concept that yes, if you go through the real life test living your life you know and you still want surgery after that then you should be able to have some surgery. It's some kind of go no go mechanism but that's not really what it should be about. And the psychological community has got the right methodology and completely wrong understanding of it. What that real test period of time needs to be is an education time - it needs to be a teaching time for the girls that are going through it. I think that there's no standards in this profession as to what you need to do during this RLT. And that needs to be written. You go to the past standards and see what it says as to what you're supposed to be learning in the RLT. It doesn't tell you anything but these are the things that the psychology community should be counseling of the women to go get done. P9*

A recommendation came from a participant suggesting an additional requirement in the standards of care to get transitioning transsexual individuals into gender support group.

*But honestly, if you're, if they're going to add a line into there anyone going through transition it should certainly, almost be required to at least have some time in support groups. P2*

As described earlier, several participants enthusiastically shared their experience and extent to which gender support group helped them in their process.

For most participants, there was an agreement that work with a clinician is of assistance in the transition process. However, there is grave concern that many transsexual individuals cannot afford the expense of seeing trained and experienced providers:

*It has to be with somebody who knows what they're doing and the people who are best at doing that in town are people in private practice. And that's problematic for folks that don't have much in the way of resources. P3*

*I really don't think it's too much to ask of someone besides finances you know - what if someone can't afford a counselor. P6*

#### **IV. Outcome of the clinical experience**

##### **Satisfaction with the clinical experience.**

Participants shared their post-transition and clinical outcomes, describing the experience and how it changed them:

*I feel so much more at peace with myself and the world. Yeah, I really do. P1*

*And certainly, my theories of transgenderism changed radically from the time before I entered transition. I'd been theorizing about it my entire life. I've told people that we're very lucky to be transgender because we get to have that transition experience. It's such a profound thing that I describe as being a roller coaster ride. When you get into it it's wild and it throws you around. You don't know where it's going to go. It's a bit frightening. And when it comes to the end, you are rolling back into the station at the end, you say*

*"Wow, that was a hell of a ride" and you want to go on it again, but you can't. It's one of those things you can't really realize what an amazing experience it is until it's over. P2*

Despite fears and reservations about seeing a gender therapist, participant 9 admits that she benefitted from the relationship and continued after it was "required."

*I continued seeing my therapist up actually past surgery. I saw my therapist for probably a little over about two and a half years total. So yeah, after I got my hormones I saw my therapist all the way up to surgery. I saw him a lot less right before surgery and after surgery you know I saw him for a little while like once a month and that was useful. P9*

Gender role transition is part of the healing process that often comes with a price. Participant 1 describes her losses, and demonstrates her determination to get her needs met at all costs:

*Well, I lost everything, that people define themselves by in our culture, I lost a \$90,000 a year job with the company Lexis, house on the golf course, wife of ten years, - the complete social structure that I had been living and working within my career. I didn't lose my family but we were estranged for a while at the beginning. Just about everything that you can think of that we use to define ourselves I walked away from. I chose to leave. And, it felt emotionally like I had walked to the edge of a cliff at night and stepped off hoping that maybe there was a net or some water or something down there, but not knowing. That's how it felt when I really made the choice to go. But, approaching that choice, there was a lot of anxiety involved with that and I was actually almost suicidal. I had feelings of, "what's the point" kind of thing. And then, you know, there was something in me that said, you know, don't give up. You need to really be who you are - and I got fired up. P1*

Although many transsexual individuals seek the clinical relationship due to the standards of care, some participants shared that they had a positive experience. The guidance and support received prompted even reluctant participants to continue their clinical relationship, even after the period required by that therapist to obtain the referral letters.

### **Perception of SOC/therapy/therapists post clinical relationship experience.**

Participants expressed an appreciation for the standards of care and the therapists who follow them. Some of the participants had a change of heart while reflecting on these issues in retrospect:

*This end of the journey I can see that it was very much necessary that there was some kind of system of checks and balances. Because I had a friend who committed suicide. Started into their transition and couldn't afford the therapy but doing what they need to do and derailed - and committed suicide. And as far as those standards of care, I'm a believer in them. So there is a need, a little bit, for gate-keeping. But on the same side the patient needs to feel in control and not left in the dark. So if there was a standard criteria check list and a standard time frame to meet. I don't know if its necessary but I like the idea because it gives somebody the chance to think about things. And make an informed decision about things. Instead of walking in in 20 years and having serious regrets. This is no different. You walk in, like I did with the augmentation. I might have had social issues or infection or regrets. Who knows. So I think there is definitely a need for some standards of care. P11*

**Researcher:** *Do you think the standards of care are a good idea?*

**P7:** *Absolutely.*

*Well I agree with the standards of care. Even though I didn't follow them. Cause I was supposed to live full time as a female for a year. Cut that short by a couple of months. P4*

*No, I didn't have a problem with the standards of care. I think the one year real life test is probably longer than it needs to be, but its not so long to be that big of a burden. P2*

*Yeah, and I heard lots of complaints, and all those things, the Harry Benjamin Standards - we should be able to do whatever we want to with our bodies. I am so grateful that I took six years of emotional transition before I started taking hormones. I really like the speed limits I have to tell you, I actually took much longer than the standards of care, and I'm really glad I did. P1*

*I was dealing with a lot during that time and I think it kinda helped to have a third person that I could go to and talk about all the issues that I was experiencing. I needed to go to him to get something, but at the same time as well I wanted to talk to someone and I may have not realized that I wanted to talk to someone at the time. But when I started talking to him and getting some of my feelings out and things like that I think I felt really good. I saw the purpose after the fact. P6*

And upon reflection, some participants still had mixed feelings about the standards of care and the requirement to see clinicians for medical referrals:

**Researcher:** *Are you opposed to the standards of care across the board?*

**P8:** *Yeah, I am. And actually, it was probably because of them that I started changing some of my views towards therapy and therapists. Now I think therapy is great! Yet, I think the only role that a therapist should have is helping them make decisions and helping them with the decisions that they've made. Outside of that, they should not be gate-keepers and should not be in a role of saying you can or can't have this.*

*I feel it should be case by case... I guess what I'm getting at I don't believe in a one size fits all. I would have probably felt very angry if I would have been told well you have to wait a year. P12*

*Well, I can tell you there's still going to be an objection to going through hurdles, but I think it's a good thing. I would counsel them to go through the hurdles. You know, like I said, when I went through it, I felt the same way. I felt a resentment about having to get decisions, that I'm making about myself blessed by somebody else. And I've also learned, over time, after seeing some girls go through surgery that didn't, that were not successful post-surgically, at living a life where they felt like I do. That this was the right decision for them, rewarded, whole. They're still broken people after surgery and the system right now is not filtering out some people that it should be filtering out. P9*

The gate-keeping role of clinicians who work with transsexual clients often causes resentment. However, there are cases and participants shared their experience of appreciating the standards of care and the required clinical sessions for assessment after the relationship ended.

### **Integration.**

Integration here refers to the social context in which a transitioned male-to-female transsexual woman lives her post-SRS life. For a transsexual woman, the culmination of work and transition usually leads to SRS. The participants described a variety of responses to completing the medical and social gender role transition.

The first group tends to move on with their lives and walk away from the transgender identity and community. In the past, this was called "stealth" or "wood-working." However, with the advent of the digital age, it is impossible to remain completely closeted after transition. Therefore, here stealth only refers to those who wish to blend into mainstream society and leave their transgender history behind them. The second group is a blend of those who have been involved in the transgender community but have begun to move onto other things in their life. Here are some quotes from those first two types of integration:

*I want to find somebody that's really nice and eventually get married. And that's where I start to cry because I really wanna get married. And have somebody that will hold me and (crying) treat me the way I want to be treated.*  
**P5**

*I'm semi-out on my job. I call my stealth now passive stealth. I don't volunteer information, but I don't hide about it anymore. I don't use the old cover stories that we were taught to use.* **P7**

*Yeah, and I've been kind of out of touch with the community for a number of years. Sometimes I think even when I'm too tired, "find a group and just kind of get in touch" because I don't interact with a lot of other trans people these days.* **P8**

The third type of integration involves moving from the self-focused act of healing and transition to a position of advocacy and leadership in the transgender community:

*I identify as a transwoman or a transsexual individual. I take enormous pride in that. And so to me the identity of being transsexual individual is not something I carry with any measure of shame. I see it as a badge of pride. I see it as an accomplishment. I still try to stay very involved in the transgender community and everything I can and try to support it. And because I think we all benefit from that, from that sense of community and camaraderie here. For new people coming into the process and for those who have already gone through it.* **P2**

*One of the things I do is I offer training for people who are clinicians who want to work with trans people and don't know how to do it. Now a days I do a lot of it.* **P3**

Of interest is the perspective and experience of participant 9 who desires to move away from her transgender life but feels more compelled to serve the transgender community as a self-less act:

*I would have preferred to just blend into the woodwork and live my life. But I had a friend of mine killed in an anti-gender variant violence. And, I had to make the decision, am I going to be public as a transgender person who I don't really identify as anymore, or am I just going to go live my life? It may not be who I wanted to be, but this is the right thing to do. P9*

After gender role transition and the termination of their clinical relationship, the participants described one of three integration experiences. Integration here refers to the client moving forward with her life after the process of gender role transition. The results ranged from moving away from associations with transgender culture and groups, while others took a leadership role in the transgender community. A few described the experience of heavier involvement and an eventual decline in connections to the community.

### **Textural Description**

The textural composite description presents the themes of common experiences of the participants as discovered through data analysis. During the data analysis, reoccurring themes were identified and grouped into core themes. Those core themes are described here in a textural composite. The transsexual women of this study described a process of discovery and self-acceptance in both their inner gender identity and their social identity. Here I will describe what the participants shared about their experience of a clinical relationship in the context of this dual process of transgender emergence.

Transsexual women generally experienced inner gender identity awareness at a young age. They also understood through direct experience or socialized learning that

they should not disclose their gender conflict. They all suppressed their true and authentic gender identity expression until late adolescence or adulthood.

At some point in their adulthood, the participants experienced a catalyst that prompted them to seek a resolution for this gender conflict. For some, the conflict was internal, reflecting an uncertainty about their true gender, for which they sought guidance to understand. For others, the conflict was with their social role or intimate partnership. The courage to move forward in their quest for wholeness sometimes came after meeting another woman who also identified as transsexual.

After making the decision to address their gender issues, participants then sought referrals to specialists who could guide them on their journey to authentic gender expression. This referral came from gender support groups, transgender mentors and community leaders, medical professionals, and electrologists. The clinical relationship was impacted by both what the client brought with them as well as (their perception of) what the clinician brought.

The opinion of the client entering into the clinical relationship regarding the standards of care impacted how they approached the relationship with the clinician. The participants fell into three groups: "I don't mind, it's part of the process," "I'll do whatever it takes to get my letter," and "I can't believe I have to go ask someone else for permission!" The clinical experience was also influenced by the clients' prior attitudes toward psychotherapy in general. Some participants expressed an attitude of appreciation for the benefits of therapy so were looking forward to the process. Other participants were resentful because they had been socialized to believe that "only crazy people go to therapy."



The transgender experience is one of isolation and loneliness. Gender support groups are attended by many transsexual women in conjunction with individual therapy. The benefits to this experience were the social support and validation. Groups were demonstrated to have great power in affirming or rejecting participants' authentic gender identity. It was in group that several participants learned of the transgender narrative that many transsexual clients use to comply with their perception of what the clinician was looking for in order to approve referral for hormone and surgical interventions.

LGBT identity politics further impacted participants in their search for validation and a search for belonging. Inner group politics within the LGBT community and the transgender community caused some participants to again question the validity of their gender identity.

The nature of the experience of the clinical relationship rests on the level of experience and expertise of the clinician. For the participants who saw clinicians who followed traditional expectations and stereotypes of transgender affirmation, the inherent rejection can postpone gender role transition decisions and processes. The experience of clinicians which adhered to a set requirement for client transition also impacted the perception of the client about the clinical relationship. For those who saw clinicians with a more contemporary view of transsexualism, the clients had a much more positive experience.

Due to the positive experience in a clinical relationship, some participants expressed a revised positive appreciation for the clinical process and the standards of care. Many expressed an interest in further revisions and clarification of the standards, but most thought that there should be some form of standards.

At the end of the transition path, participants take different paths to integration. Some chose to move forward with their new life in their authentic gender role, while others returned to the transgender community as leaders and mentors to new transsexual individuals seeking guidance for gender role transition and medical intervention. The group of moderate community involvement included those who started there after transition, as well as those who drifted away from the intensity of community leadership after a period of time.

This textural description provided a composite report of the data analysis about how male-to-female transsexual women experienced a clinical relationship. The next section will describe findings regarding the structures upon which the textural experience is founded.

### **Structural Description**

The structural description encompasses the structures that create the foundation and context for the textural description of the phenomenon. This section will review several structures that emerged from the data: stigma, oppression, self-preservation, fear, sexism, identity politics, and generational trauma.

Stigma is described by Goffman (1963) as a social structure by which a group in power labels an individual or group as deviant. The social mark of stigma is clearly demonstrated in the social perception of gender variance. It is stigma that most impacts transsexual women who wish to transition their assigned gender role. If gender variance was not perceived as a moral defect, sexual perversion, mental illness, or character defect, the need for such scrutiny while transitioning gender role would be much less dramatic and painful for all involved. It is the label of social deviant that causes

transsexual women so much angst during their search for understanding of their authentic gender identity and the emergence process. The major losses of friends, family, and employment are all created by stigma. The transsexual women perceive those who feel the need to distance themselves from her as precipitated by the stigma associated with her transsexual identity.

Oppression is an extension of stigma. In this context, oppression refers to the removal of basic human and civil rights for transsexual individuals. It is the possibility or experience of oppression that drives the transsexual client to question their authentic gender identity, out of fear of the resulting losses of rights and basic dignity. Oppression can also be experienced in clinical relationships. The authoritative and judgmental stance of some clinicians oppresses through denial of access to necessary medical care.

It is the innate human quality of self-preservation that drove the participants to pursue gender role transition, despite the stigma, oppression, and potential losses they faced. Self-preservation also precipitated the use of a transgender narrative for clinicians they perceive to have the power to approve or reject their request for access to medical care.

The experience of fear permeates all the experience descriptions and themes presented from the data in this study. Participants have conflicting feelings about how their gender identity is viewed by their gender specialist. They feel afraid that their clinician will diagnose them as transsexual, resulting in potential social losses. Others feel fear that they will not be diagnosed as transsexual, denying them affirmation of their inner identity and access to needed medical care. The fear that is experienced points to the quality of the clinical relationship and the innate imbalance of power in this situation.

Sexism and heterosexism are factors in the social experience of transsexual women. Gate-keeping for genital surgery for male-to-female transsexual clients is required whereas it is not required for other body modification procedures. The surgical removal of the phallic symbol of male power was perceived as a threat to the status quo of power delineation in our society. Sexism also permeates the pathologizing of natal males who would choose to alter their body and social role to one of a lesser status.

Stigma, sexism/heterosexism, and oppression have an impact on in-group identity politics of transsexual women. This issue causes division within the LGBT community and caused some of the participant's anxiety when they were looking for affirmation. These identity politics tend to draw attention away from the activism for LGBT rights and equality.

The concept of multi/inter/trans-generational trauma has been generally used in analysis and description of the experiences of holocaust survivor descendants, or the history of Native Americans surviving genocide and cultural annihilation. Similarly, the structure of generational trauma can also be applied to the experience of transsexual individual women as illuminated in the data for this study.

Participants described the experience of hearing about other transsexual individual women who were rejected by clinicians based on outdated selection criteria, or even worse, legends of those who were institutionalized and given electroshock therapy. It is this historical context that continues to drive some of the fear for those who are considering gender role transition.

Generational trauma is also a structure that instigates the use of an outdated transgender narrative. Although the standards of care have been revised, there are

clinicians and transsexual individual community leaders who are not aware of the evolution. This act of sharing historical experiences and outdated knowledge perpetuates misinformation and harm to transsexual individuals.

### **The Essence of the Experience**

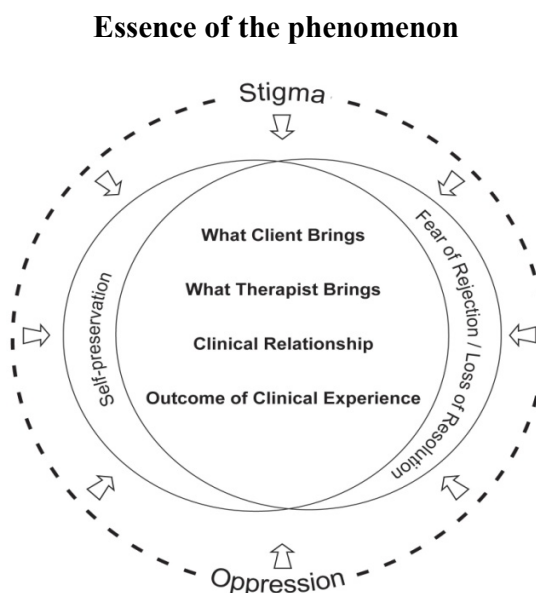
*When I was 13, my babysitter had some emotional problems and ended up in a mental institution. I went to visit her and she told me about another patient there who was a boy but wanted to be a girl. She told me that they gave that "boy" a bunch of shock treatments, then they did some kind of surgery that turned him into a vegetable - I think it was a lobotomy. That was right before my parents made me go see a psychiatrist because I got caught in girl's clothes. I knew better than to tell him anything so I kept my mouth shut. I didn't want shock treatments or a lobotomy. P10*

The textural description illustrated a composite of the clinical relationship and a common pattern of experiences based on the data. The structural description outlined some structures that were a foundation for creation of the textural description. Moustakas (1994) defines the essence of the experience as a "brief description that typifies the experiences of all of the participants in a study." This is the final reduction in analysis of the data based on the textural and structural descriptions.

The data from this study provided a textural description of the processes and experiences of male-to-female transsexual women who transitioned with the aid of a clinical service provider. What was learned is that the clinical relationship between the transsexual individual client and the clinical provider was impacted by the histories and expectations of both parties in the relationship. The structural description explored the structures that were the foundation for these experiences - stigma, oppression, self-preservation, fear, sexism, identity politics, and generational

trauma. It is the composite combination of these concepts that provides the *essence* of the experience of the participants.

The underlying theme that runs throughout the experiences of the participants is that of *self-preservation driven by fear*. Fear permeates the process of participants who worry about loss, rejection by family and friends, and invalidation from the clinician who is charged with approving clients for referral to receive necessary medical care. It is the self-preservation that keeps transsexual individual women on the track (or coming back to) gender role transition. It is the self-preservation instinct and tenacity that prompts clients to present a memorized narrative, "manage" their therapist, and rush towards surgical procedures in order to avoid the process being halted for any reason. It is this self-preservation that pushes these women to complete that transition, sometimes to their own detriment - moving through the process without adequate time for emotional, psychological, and physical integration of the change.



**Figure 4**

## **Chapter Conclusion**

This chapter presented data from the verbatim transcripts of 12 participant interviews. The invariant constituents were grouped into four core themes: What the clients brings, what the clinician brings, the clinical relationship, and the outcome of the clinical experience. The textural and structural composites were presented, along with a brief description of the essence of the experience - self-preservation driven by fear. Chapter 5 will explore discussion of these themes and findings, implications for social work, and conclusions.

## Chapter 5: Discussion

*You have a group of pioneers moving into a new land. I think of myself as an immigrant - I have immigrated into womanhood. And there was a time in my life when natural born citizens of that land would recognize that I was not a natural born citizen. But, no longer. I have been living in this country long enough that I've got it right and I am seldom detected.* **Participant #7**

### Discussion of the Findings

The purpose of this study was to increase understanding of transsexual women's experience of clinical relationships. By using phenomenological methods, I was able to contribute to the knowledge provided in the existing literature through the voices of transsexual individual women themselves. I collected data until the themes and patterns were redundant and clear. This chapter will explore those themes and findings, as well as present implications and participant recommendations.

#### **Gender immigrant analogy.**

The above quote provides a helpful analogy for us to understand the essence of the experience. She uses the analogy of gender immigrant to describe her gender role transition. Immigrants move from one country to another, frequently with the hopes for a better or more comfortable life. Unfortunately, people who emigrate from other countries are considered racial or ethnic minorities when they arrive in their new country; they sometimes feel frustrated at the lack of acceptance based on their appearance, language usage, or cultural customs. Many immigrants choose to assimilate into mainstream behaviors and appearances as best they can, in order to feel more accepted in their new country, rather than acculturate, retaining their cultural traditions, values, and language (Vermeulen, 2010).



Historically, transsexual women who transitioned were expected to assimilate into the stereotype of how society expects a "real" woman to appear and behave. This is no longer acceptable in relation to the evolving norms about diversity and multi-culturalism in the U.S. (e.g. expecting foreign born Americans to imitate our Euro-American culture and customs). Although "politically incorrect," this expectation based on stereotypical cultural norms still exists for many transsexual women. Mainstream society more readily accepts transsexual women who have physical attributes such as height, hairline, facial shaping, and body hair consistent with natal females. Not only is their physical stature judged, but their social demeanor and presentation as well. Women who walk, talk, and communicate in a more stereotypical fashion are accepted as "real women" more easily than women who were socialized to walk, talk, and communicate in the manner expected of men (Bockting & Coleman, 1992; Stone, 1991).

In American culture, the transgender community is involved in an identity politics debate about societal expectations of transitioned men and women to assimilate and gain acceptance in mainstream culture. In the case of participant 7, she is pleased that she has accomplished that goal of female gender assimilation. Although this study was not intended to be a review of transgender politics, it is important to understand that gender role assimilation is a goal of many transsexual women, and part of what they bring to the clinical relationship. Historically, part of the transgender clinical legacy was to only approve those women who "passed" as "real women" after transition (Lev, 2004).

The gender immigrant analogy also applies to the emotional and psychological process of the transition of one's social role from something familiar, to a role that has been learned through later education/socialization. Older immigrants have more difficulty

in mastering cultural norms and expectations due to years of cultural habits (Morozov, 2008). Similarly, older gender “immigrants” have more difficulty changing socialized behaviors if their goal is gender role assimilation. Transsexual women of all ages are subject to disappointment after transition if they are not perceived to have mastered assimilation, but older gender “immigrants” are particularly vulnerable. Sometimes there is "magical thinking" on the part of women in transition regarding their acceptance post-transition. They believe that once they present themselves in their authentic gender (especially after genital correction) they will be completely accepted by others because they feel completely female (Lev, 2004). Just as American immigrants are often surprised and disappointed by their lack of acceptance in their new country, so are gender immigrants dismayed at the rejection. Immigrants and refugees often focus on leaving an environment that is unfulfilling or unpleasant, but do not foresee the possible complications of social acceptance in their new land. This disappointment and possibility of regret is what the standards of care and “real-life experience” recommendations attempt to address. Clinicians who see older gender immigrants need to be aware of these additional challenges.

### **Generational trauma.**

Generational trauma is defined as secondary trauma that is transferred from parent to child, also referred to as multigenerational, intergenerational or transgenerational trauma (Davidson & Mellor, 2001). This concept is primarily used in the literature to describe the phenomenon of secondary trauma passed from Holocaust survivors to their children and grandchildren (Danieli, 1998). Doucet & Rovers (2010) describe four possible causes for the transfer of trauma from one generation to the next: 1. vicarious

identification of children with their parents' suffering at similar stages of chronological development, 2. compensation by children for their parents' suffering, 3. parenting patterns exhibited by survivors, and, 4. communication of trauma between parents and their children.

The transsexual woman experiences the transfer of trauma primarily through the communication of trauma from previous transsexuals' experiences and through identification with the traumatic experiences of prior transitions of older transsexual individuals. The generational trauma is created at two target points. For some, merely hearing the devastating histories of previously transitioned women can cause unintended secondary trauma through vicarious empathy based on their shared identity. When people hear traumatic stories, such as hate crimes perpetuated on the transsexual population, there is potential for secondary trauma to take place. Brutal attacks on transgender women have been recorded (Swigonski, 2006), and they sometimes share these accounts in support groups.

The second point of generational trauma is brought forward in the findings of the study. When transsexual women share their histories in support groups, there is a passing on of dated information regarding the transition process. The experience that transsexual women have had in the past (and occasionally in the present) can be very different from the social climate now. More information has been presented to mainstream society through multimedia sources, therefore changing the overall social attitude towards transsexual women. There has also been some increase in the training of clinicians regarding transgender care, improving the odds that transsexual women seeking clinical care will receive more appropriate treatment. Hearing the painful stories that have

plagued the transsexual community passes along the trauma and reinforces the fear that sometimes keeps transsexual women in the closet. It is this legacy that is transsexual generational trauma.

Clinicians need to be aware that transsexual women not only bring their personal history and prior perceptions and expectations, but also the legacy of transsexual women in clinical relationships that has been passed from one generation of transitioning women to another within the tight-knit community. Once the catalyst event has occurred for a transsexual woman, she often turns to a gender support group to learn about the process of transition. It is there that they hear of the historical legacy of rejection, failed transitions, and the power differential experienced with therapists. Although this history is important to pass on, it also sometimes has an unintended traumatizing effect on the women who are just beginning the process. Part of the reason that many transsexual women don't transition sooner is the previously described fear and self-preservation. Upon experiencing the catalyst that prompts them to consider transition, stories discovered in support groups and on the internet reinforce those fears. Some caution is still warranted, given our society's current state of oppression and misinformation. However, media dissemination of information on transgender/transsexual experience has greatly increased the social acceptance and transition success rate (Meyerowitz, 2002).

**Essence of the experience; self-preservation driven by fear.**

Fear for transsexual individual women arises in many facets of the transition experience. The primary fear is the fear of loss and rejection. Second is the fear that once the individual's courage and will initiates the beginning of gender role transition, somehow the process will be halted. That fear is most prevalent while engaging in a

clinical relationship with a therapist who has the responsibility to conduct an assessment for medical treatment needed for transition (SRS). As stated in the findings, there is a fear that not only will the clinician deny medical care, but also may deny or invalidate the authentic gender identity of the client.

Self-preservation plays a dichotomous role in the transition process as well. It is self-preservation that keeps transsexual individual women safe and suppressed. The other side, the need to express the authentic self, eventually wins out and the role of self-preservation is reversed. The transsexual individual woman then feels that she will do whatever it takes to succeed in gender role transition and acquisition of necessary medical procedures:

*So I think I think I was in the mind frame I don't know if I knew at the time but I was like I'm gonna do anything to get this done. You know not gonna be able to stop me. I have that survivor mentality so even though I did have a lot of anxiety um about the letters um I felt that I...I would find some way or I would or my mom would find some way. P6*

*I was a resourceful child and I knew a pharmacist that would give me things for exchange of sexual favors. I wasn't offended. I didn't feel negative about the experience though it wasn't exactly my experience of choice. But, it was an easy price to pay. I think I've looked at most of my life as being, well, that's the price of admission. P7*

*This is survival we're talking about here. And, and so, the management of psychological professionals to my own benefit was no was nothing more than an extension of the same survival skills that I'd already learned. P9*

It is important that clinicians be aware of this self-preservation in the transition period. The above quotes capture the desperation of the clients as they approach a clinical relationship. Awareness by the clinician can guide the client in the clinical process with improved empathy and a focus on empowerment of the client.

### **Core themes.**

The findings included four core themes - what the client brings to the clinical relationship, what the therapist brings to the clinical relationship, the clinical relationship, and the outcome of the experience. As in all relationships, the connection between two people is impacted by their prior perceptions, expectations, and goals for the interaction, as was demonstrated in the data from this study. Participants discussed their prior perceptions and expectations going into the relationship, and many stated how those perceptions were changed by a positive clinical relationship during their transition process.

#### ***What the client brings.***

The findings chapter began with an exploration of what the client brings to the clinical relationship. The process for many began with an emerging awareness and understanding of their innate inner gender identity. Participants stated that it was difficult to express or pursue gender role correction when there was not a social framework or language to describe this need. The combination of lack of information in society about gender variance, and the historical stigma associated with gender variance and non-conforming gender expression made it nearly impossible to gain understanding of this experience for those living with the condition.

Once the inner identity was better understood, the gender variance was quickly also understood to be an experience that carried stigma. This stigma triggered fear of being discovered as gender variant and precipitated a fierce sense of self-preservation, keeping their inner gender a well-kept secret. It took a catalyst - a chance meeting with a transgender person or a media source presentation regarding transgender issues to

motivate the participants to emerge. For some of the participants, the emergence came in stages after they developed an understanding of their inner and social gender identity. For these participants, the catalyst was a personal crisis when the conflict and suppression became too painful to hide and they sought out information and guidance.

The referral for clinical assistance came from several different sources: a gender support group, a transgender friend or mentor, a medical professional, or their electrologist. Referrals came from the first or second contact they made after deciding to address their transgender issues. For those who used the internet, the gender support group was frequently the first place they openly admitted that they were experiencing gender role conflict. After summoning up the courage to attend the group, the advice they usually received was to seek a clinician to help them with the process, receive an assessment, and get their referral letter for hormone therapy. When the catalyst was a chance meeting with another transgender person, the referral often came from that person at the time of the chance meeting. Yet others immediately sought medical help, not realizing that they would not be able to obtain hormone treatment without a clinical referral letter. The medical contact then gave the participant the name(s) of gender specialists.

Perhaps one of the most unusual findings of this study is that several participants received recommendations for a clinician from their electrologist. Due to gender identity confusion based on denial and fear of stigma, some transsexual women explore the possibility of a cross-dresser identity. This period of exploration can lead to permanent but more subtle body modifications such as hair removal. The process of hair removal is very painful, intimate, and long-term. It is the electrologist that sometimes first hears

about a transsexual woman's fears, concerns, and authentic gender identity. If an electrologist works extensively with the transgender population, she is usually familiar with local transgender resources and passes along those referrals.

As a transsexual woman learns more about her social identity and the process of correcting her gender role through body modification, she also learns of the standards of care requirement to see a clinician before proceeding with hormone therapy and surgical corrections. The participants had different responses to this part of the process. Some women understood that clinical work was just another step in the process and did not mind. Some were resentful, but felt that they would do what it takes to advance to the next steps of transition. Some participants were extremely resentful and did not like that they were being required to see a clinician for approval to obtain medical care for a physical condition. Whatever their reaction to this part of the process, it had a direct impact on their willingness to fully engage with a clinician.

Participants with all of the above reactions to the requirement were acutely aware of the power differential in the clinical relationship. Several participants described their fears about rejection, mislabeling, or judgment on the part of the clinician, which jeopardized their confidence, and could prohibit access to necessary medical interventions via a letter of referral. These issues affect the level of trust between the client and clinician as well as setting a tone for open communication. Impaired trust was minimal for some, transitory for those who developed trust over time, and some participants never established complete trust and respect with their clinician. For those with lesser degrees of trust and respect, elements of potential clinical assistance were lost.



Participants who were most focused on the necessity of medical treatment experienced a greater intensity of fear and self-preservation. Participants also expressed a concern that there has been too much emphasis on the genital surgeries, rather than the issues surrounding the social transition. The focus on the genital surgeries was reported as problematic by other transsexual women they met in groups and in social circumstances. The focus on genital surgery also perpetuates the condition as one of a sexual nature rather than identity, when so much angst is placed on who is approved and who is not given referrals for surgical care. Although they agreed that surgical intervention is helpful in relieving some of the gender dysphoric feelings, it is the social gender role transition that is most important to them. An underlying implication is that it is our sexist society that places such emphasis on genitals and gender identity; sexism and the phallic power of the masculine creates and perpetuates the idea of gender incongruence as a perversion rather than a medical condition.

Another factor that impacted the clinical relationship for participants was their prior perception of psychotherapy or clinical work in general. The stigma associated with mental health services and problems acts as a barrier to viewing clinical intervention as beneficial. In contrast, those who grew up with an appreciation for the benefits of clinical work looked forward to this part of the gender role transition process.

Gender support group involvement was of vital positive significance to many of the participants. They shared their group experience with great enthusiasm and strongly recommended this for anyone who wishes to change gender roles or explore their non-conforming gender identity. It was in group that participants were able to feel affirmed when hearing stories and experiences that were similar to their own. Group members

share their struggles with validation of their gender identity as well as the social struggles that are initiated through openly admitting an identity associated with stigma. Some participants stated that the group experience was as helpful, if not more helpful, than individual clinical work. Information regarding the mechanics of the transition process were often obtained through the knowledge and resources provided by group members. The group experience appears to be of great benefit as an adjunct tool to clinical work in the process of gender role transition.

However, support groups and gender identity politics also contribute to animosity and misunderstanding among gender variant people and within the LGBT community. Identity politics within this marginalized population appears to be causing some additional confusion and lowered confidence as transsexual women work towards their target gender role. Roen (2001) studied these transgender identity politics and found that there is a struggle between those who believe that it is imperative to embrace all gender diversity, and those who believe that transitioning transsexuals must assimilate through their target gender role to gain social acceptance and validity. Participants in this study reported rejection from the very support groups they relied on to boost their self-esteem - excluded because they are seen as different. This kind of rejection based on transsexual stereotypes can precipitate further questioning of a person's identity and a retreat back into isolation and suppression.

***What the clinician brings.***

The three factors that clients described as having impact from their clinicians are the level of knowledge and experience, the degree to which the clinician adhered to their

perception of the standards of care, and the theoretical approach to practice with transgender/transsexual clients.

Transgender clients are particularly vulnerable and rely on the clinician to be informed regarding the guidance and care needed in providing clinical services. This is still an emerging practice specialization, and there are many clinicians who are uninformed, misinformed, or not aware of standards and guidelines that are continually being revised. Uninformed/misinformed clinicians can cause great harm, or at the very least cause additional distress and shame for vulnerable clients. As in all areas of clinical practice, clinical experience with the population being served requires extended learning via literature or training. It is important for clinicians to avoid the mistakes that cause clients' pain from past practices. Knowledge and experience do not correct all errors in clinical practice with this population, but it increases the likelihood that the client will have a beneficial and positive clinical relationship experience.

As stated above, the standards of care and the understanding of appropriate clinical practices progresses over time and with new information. Older standards of care had more stringent requirements for clients to meet in order for clinicians to write referral letters. The degree to which the clinician adhered to their perception of the standards of care guidelines was one of the factors that impacted the level of trust, therefore the overall experience of the clinical relationship. Some participants were amenable to the requirements set by their clinician, but several felt they were required to attend sessions or live the real-life experience longer than necessary because their clinician required it. The overall consensus was that the standards of care guidelines should be individualized - flexible and applied in a variable manner, dependent on the needs of each client.

The third component participants identified as a factor in their experience of the clinical relationship(s) was the overall theoretical approach their clinician used when working with the transgender/transsexual population. A dated theoretical approach can come from different sources: lack of knowledge, dated knowledge (they learned old approaches and did not update with changing times), or a general perspective based on a conservative paradigm of pathology. This perspective generally views gender variance as dysfunctional and/or a sexual perversion. Contemporary perspectives generally support gender variance as just that, human variance. Dated perspectives include forcing gender variance into one or the other of the two designated sexes and reinforcing the binary gender paradigm. This can be harmful, or at least unhelpful, to women who desire transition but who do not fit traditional expectations of female gender role behaviors and appearance. Women who identified as lesbian in their target gender, or who did not fit the stereotype of female presentation were shut down in their attempts to transition by clinicians who followed these antiquated ideals and expectations.

### ***The clinical experience.***

The primary focus of this study was to gain an understanding of the clinical relationship from the viewpoint of the transsexual clients' experience. The participants highlighted several aspects of the clinical relationship, which were grouped into common themes: trust, the transgender narrative, support and affirmative listening, guidance, and case management.

Due to the factors described in previous sections, trust within the clinical relationship can be compromised by both clients and clinicians. The power differential created by the gate-keeping function, which requires referral letters for SRS, immediately

puts the transsexual client at a disadvantage. It is difficult to trust the clinician, and this is exacerbated by the generational trauma and legacy of rejection experienced by the transsexual population. In turn, clinicians have learned of the self-preservation behaviors of clients in this type of relationship and often do not trust that the client is telling the full truth. The findings reveal that clients have grave concerns about obtaining the referral letters they need and sometimes provided their clinician with what they felt the clinician was expecting to hear, thereby managing their therapist in the process.

The legacy of clinicians denying referral letters has created a parallel legacy of transsexual clients learning what has been expected by clinicians. Prosser (1998) identifies this as the transgender narrative and has explored the history of the development of the transgender narrative. The narrative is an expected set of “symptoms” or descriptions of the transsexual experience initially gathered while the diagnostic criteria were being developed. The data gathered was from a set of transsexual women and then presented as the only legitimate list of criteria for “true transsexualism.” Clinicians learned of these criteria and compared the experience of all subsequent transsexual women to this list. Within the transsexual community, it was quickly learned what criteria had been established and the information was passed from generation to generation of transsexual women who desired transition.

The transgender narrative used in a clinical setting works to undermine the efficacy of that work and impacts the trust issues discussed above. Self-preservation forced some participants to choose the memorized narrative rather than risk rejection by sharing their honest experience. Although the transsexual client receives the letter she

needs for medical care, she also forfeits the benefits of processing the transition, which may provide a stronger, more confident and therapeutic transition experience.

Effective clinical work with a therapist, according to these findings, was based on affirmative listening skills; the clinician listened to what was important to the client, rather than telling the client who they are and how their life should proceed. Affirmative practice allowed the participants to relax, trust the relationship, and benefit from reduced sense of fear and shame.

The clinician who offers guidance provides the opportunity for the transsexual client to fully understand both their inner and social gender identity. Clients experience confusion based on misinformation or lack of information regarding gender variance and the identity options available. Driven by fear, shame, stigma, and self-preservation, some of the participants shared that they were hoping that their clinician would affirm a cross-dresser identity rather than a transsexual identity. A cross-dresser identity would be more likely to allow them to experience reduced stigma and far fewer losses and personal life disruption. A skilled and knowledgeable clinician could guide them to a clearer understanding of the process of discovery as well as affirmative recognition of a transsexual identity.

The process of gender role transition can be frightening and confusing. The clinicians who acted as guides successfully worked with participants by providing a roadmap for the journey of transition. The roadmap includes case management functions as well as clinical relationship skills. It is the case management aspect of the clinical relationship that reinforces the importance of social workers providing clinical services to transsexual clients; they are best trained to do this kind of specialized clinical work. Case

management includes working with partners and families of the transsexual client, as well as providing referrals for the complex set of procedures that most surgical candidates need for successful gender role transition. Some participants reported that their therapist was part of a gender team, or was in regular contact with other clinicians so that the second letter needed for surgery was easily obtained by the client.

***Outcome of the clinical experience.***

The clinical experience had some unexpected results for participants. Though there was initial reluctance to engage with a clinician, the development of a positive working relationship with their clinician led to feeling better about themselves and their transition. Relationships often continued even after it was no longer “required.” Transsexual clients found themselves changing their opinions about the standards of care, psychotherapy, and the usefulness of this part of the emergence and transition process. This change of opinion appears to have been achieved through the use of good clinical skills and the reduction in anxiety of the client regarding the gate-keeping aspect of the clinical relationship.

Positive outcomes of the clinical relationship and subsequent successful gender role transition were reported by participants, resulting in a sense of fulfillment. While several participants reported great losses in relationships, income, and social standing, all stated that they felt more secure and comfortable with themselves. Much of this resolution was primarily due to the relief brought about from the gender role correction, but some of the resulting success was due to their work with gender affirming clinicians.

After full gender role transition and genital correcting surgery, participants outlined a few common post-SRS life choices. A few participants described what used to

be called a stealth life-style. This meant that the participant changed gender role, along with their social identity and avoided public acknowledgment of their previous male social gender role. With the advent of the current digital age, “stealth” is virtually impossible due to easy access to information by the public. However, many still strive towards complete female gender and social role assimilation, hiding their male gender role from their earlier life. Other participants became mentors, activists, and public advocates for transgender people. These fully transitioned individuals felt compelled to give back to the community that supported them, as well as improving the future for those transsexual individuals who will follow in their transition footsteps. The third group included participants who described a life of moderate involvement in the transgender community. Some entered this category of post-transition life immediately after SRS, and some gravitated towards this moderate involvement after an initial, more intense state of activism. After a period of time, the desire to remain immersed in the transgender community is replaced by a need to move on with their new gender role life. This moderate involvement life-style keeps them connected, but not to the extent they sought immediately after SRS and transition.

## **Implications**

### **Implications for social work research.**

This study explored the experience of transsexual women who entered into a clinical relationship in the context of gender role transition. This study focused on transsexual male-to-female adults who identified with the gender binary, and chose to assimilate their target gender role. In future research, it would be important to include other forms of gender variance, additional focus on younger transsexual adults, as well as



children and adolescents, and wider racial and ethnic diversity, in order to identify a broader range of experience. Although a range of diversity in sampling was achieved in this study, there is a need to differentiate the needs and experiences of transgender children, adolescents, and young adults due to life span and generational differences. A transgender child or adolescent entering into a clinical relationship will have greater need for understanding, because they are additionally vulnerable due to their age and lack of life experience. Minors are under the care of adult parents who have control over their care. These additional factors may impact their ability to articulate and express their concerns regarding their gender variance.

Research regarding clinical practice is needed to support the growing body of literature that describes clinical practice based on anecdotal experience. Affirmative and evidence-based practice will provide transsexual clients with the best possible care. This study highlights the need for greater communication between client and clinician, as well as addressing the gender politics that may enter into the clinical relationship. Further research into the impact of transgender politics on the clinical relationship will clarify a beneficial path for the clinician when doing intake with new transgender clients.

Many years have passed since the initial conflict over Bailey's research and the fallout, and additional time will heal some of the resulting distrust of researchers. More credibility is needed to increase transgender involvement in research. This can be accomplished with additional studies with transgender researchers, more qualitative research with transgender participants as co-researchers, and research regarding the direct impact of the Bailey controversy on current research. Due to the history of clinical practices with transgender clients, in combination with the Bailey controversy-driven rise

in distrust of researchers, research regarding the clinical experiences will continue to be challenging.

One area that was not explored in this study, but should be considered for future research, is the impact of religion on the transgender/transsexual client entering into a clinical relationship. Different religions have varying responses to a transgender identity and experience. This impact of religion would be significant to study to gain insight into the core theme of what the client brings, as well as what the clinician brings to the clinical relationship. Individual perceptions of transgenderism based on religious beliefs will directly impact possible value judgments and transphobia on the part of either side of the clinical dyad.

This study closely examined the experience of transsexual clients in a clinical relationship. Findings produced core themes describing the impact of the relationship based on what both the client and the clinician bring to the relationship. Further study into what the clinician brings to the clinical relationship will complement this study and add breadth of data to the clinical phenomenon of a transsexual client and clinician.

Qualitative methods were used for this study to obtain thick description of the phenomenon. Additional research is needed using mixed methods and quantitative approaches to develop instruments that can further the understanding of transsexual experience via data that can be generalized.

### **Implications for social work practice.**

Social work is the profession with the best suited skills to assist the needs of transsexual individual clients (Wicks, 1977). As demonstrated in the data presented from the participants, clinical skills needed include resource brokering, case management, and

psychotherapeutic interventions. There is often a need for couples and family work, as well. Because this population is still emerging in society's awareness and acceptance, advocacy and activism is also part of the social workers' engagement with transsexual individual clients. Not all social workers are fully trained in all of these areas, but generalist social work practice allows for clear assessment of needs and training for brokering of resources for areas where they are lacking. The void of social workers involved in transgender care is an issue that should be addressed by our association, as well as the responsibility of social work practitioners, to engage with this underserved population. Greater numbers in WPATH, as well as taking a lead in advocacy for transgender clients, will assist in moving this population forward.

Based on this study and previous research, a recommended clinical framework is an ecosystems approach to assessment and intervention that captures the levels of stigma, environmental stress, interpersonal relationships, and economic factors experienced by transgender/transsexual clients. Findings from this study indicate that stigma and oppression have an impact on the clinical relationship explored in the core theme of what the client brings. Using the ecosystems approach will open the clinician up to evaluating environmental impact on functioning and ability to engage in the transition process. This approach also moves clinicians away from a psychopathological view of the transgender experience, focusing on person-in-environment rather than pathological non-conformity. Awareness of economic factors will also assist the clinician in understanding access to care issues that frequently exacerbate the experience and delay appropriate medical intervention.

Some of the focus of this study was on the impact of clinician as gate-keeper for transgender access to medical care. It would be helpful for clinicians to convey a stance of clinician as gate-opener. This paradigm shift can assist in trust building and confidence for the transgender client. When the clinician is seen as an advocate and person who guides the client to access to care, the client can benefit from the increased trust and partnership in the clinical relationship.

Many clients engage a clinician in pursuit of assessment for access to surgical intervention. Clinicians can improve the clinical relationship with an approach of empowerment and transition guide/assistant. This approach of partnership removes the distress of clinician as judge and allows the client to work towards a successful transition, rather than focusing solely on access to surgery. In social work practice, case management skills are helpful for this reason, supported by findings in this study.

#### **Implications for social work theory.**

The findings from this study are supported by the theories outlined in the literature review: Labeling theory, symbolic interactionism, and Lev's transgender emergence developmental stages.

The findings contribute to the literature on labeling theory which suggests that people in power (often dominant groups, professional experts, etc.) have the ability to label individuals and populations perceived as different from them as deviant. When one is labeled deviant, especially as mentally ill, the labeled person can become distressed, stigmatized, and oppressed by the label. In the case of transsexual individual women, the inclusion of gender variance in the DSM perpetuates the fear of outsiders that transgender people are mentally ill, sexually perverted, and dangerous to society. Pathologizing

difference has happened with other populations, such as the inclusion of homosexuality in the DSM, but this was later revised (Winters, 2008). Gender variance is another “label” that must be removed from the category of pathology..

Symbolic interactionism is demonstrated in the data that describes participants' search for social constructs that clarify their inner gender identity. The meaning of their identity was clearly connected to the interactions they experienced with others, as argued by Blumer (1969). Several participants stated that they were unsure of their social identity until the option of a gender variant identity was presented to them. The current trend of transgender emergence by growing numbers of gender variant people suggests that as media provides increasing volumes of information regarding transgender identities, more people are confident in their identity and able to express their authentic gender.

Lev's (2004) transgender emergence stages of development is based on her clinical experience with transgender clients, and recently supported by results from researchers. Her stages closely matched several of the core themes, particularly the flow of themes demonstrated in figure 3. The process of transition corresponds with a developmental process that has particular stages associated with it. "Awareness" matches the "emerging awareness" category under the first core theme - what the client brings. "Seeking information/reaching out" from Lev's model follows with the categories of catalyst and referral reported by participants in this study. Lev's stages of "Disclosure to significant others," "Exploration - identity and self-labeling," and "Exploration - transition issues" were implied in the themes discussed by participants as “What the Client Brings” and “The Clinical Relationship,” even though the study was focused on

the clinical relationship, rather than the social process of transition. The final stage of Lev's model, "Integration" has a strong connection to this study's final core theme of Outcome, and the category listed as integration. Lev's stage addresses identity acceptance and other post-transition issues, which correspond to the discussions regarding participants' choices about their social identity and levels of involvement with the transgender community. One might argue that the degree of involvement may depend on their acceptance of their social label as transsexual.

### **Implications for social work education.**

For most clinicians, specialized training in how to care for transgender clients has been non-existent, or scant at best. However, there is a growing number of transgender individuals emerging due to media and internet information and support who will need clinical assistance. Due to this increase, it is likely that non-transgender specialist social work practitioners will see transgender clients at some point in their professional careers. In addition, there are still a significant number of clinicians who work with transgender clients but use antiquated, biased, or harmful techniques for treatment (Lev, 2004). Historically, it has been common for therapists to judge and label transsexual individuals based on stereotypes of what a transitioned transwoman should be.

The transsexual community is leery of the helping professional community. They pass along their horror stories and keep guarded lists of those who have treated transgender clients well, and those who have not. It is important to educate social workers who may serve transgender clients in their practice in order to provide quality care. This education can take place with the integration of content on the transsexual experience, the transition process, and gate-keeping standards into Bachelors and Masters of social work

programs. Included in this integration would be field experience opportunities for social work students. A certification program that encourages full disclosure of transgender population issues will assist both future social workers in their clinical preparation for direct practice, as well as inform potential clients about who has had prior gender specific training.

Training for social work faculty will confront their lack of knowledge about the transgender population, and allow them to learn, so they may appropriately and adequately address this in their curriculum. Training of this nature at conferences aimed at social work faculty can challenge any potential biases or lack of knowledge that educators are experiencing.

Professional development opportunities for clinicians through NASW and other social work conferences, and also connected to social work programs at universities, will provide greater training for clinicians who will see transgender clients in their professional practice. Because so little is taught in social work education regarding the transgender population, it is important to provide these learning opportunities for clinicians who are no longer in school but need the training.

### **Implications for social work policy.**

The significant policies that impact social workers and their transgender clients are the standards of care that force social workers into a gate-keeping role, as well as the DSM inclusion that pathologizes gender variance. It is imperative that social workers become more involved in the policy-making that impacts our ability to appropriately serve our transgender clients. The participants in this study expressed the need for some form of standards of care for transgender clients, but revision should reflect the need for

flexibility and appropriate application of these standards. Many of the participants stated that there should continue to be some form of assessment for readiness and informed consent when seeking medical body modification, but adjustments in the current and former standards legacy will allow those who are ready to avoid unnecessary steps towards their goals.

DSM inclusion has been argued to be a way for insurance companies to provide medical care. However, most insurance companies in the United States do not allow for transgender specific reimbursement or support. Other countries have adopted the DSM equivalents as a basis for transgender care and reimbursements. The solution would be to move a form of this diagnosis from the mental health section of the International Code of Diseases (ICD) to the non-mental health sections. This would assist in removing the stigma and misperceptions associated with gender identity as a mental illness. It may also move to clarify and distinguish gender identity from sexual orientation. A normative approach to gender variance will greatly reduce the associated stigma that transgender and transsexual clients experience.

The recommendations listed above will move towards implementation with advocacy and support from social work educators, practitioners, and policy specialists.

### **Participant Recommendations**

This study was initially created with the purpose of giving voice to the marginalized transsexual population. To this end, it was important to share their direct responses to the questions, "What did your therapist do right?" and "How can we do it better?" Their responses were presented as data that supports the findings of the phenomenological questions asked in the interview schedule.



## **Strengths and Limitations of the Study**

### **Strengths.**

This study used qualitative methods with a marginalized population to give them voice. The questions were open ended, providing an opportunity for participants to offer more descriptive depth and breadth of experience. Qualitative methods also provide a mechanism for bracketing bias to increase the credibility of the study.

Due to my level of immersion in the transgender community along with my years of clinical skills and experience, participants were more comfortable and felt trust with me as a researcher, addressing the earlier concerns documented about distrust of research with this population:

*They should make you a TV interviewer because you ask the right questions. They don't. they want the freak show questions. When was the first time you put lipstick on? Whatever. P11*

*I have been pretty brutally honest about what I did in my clinical relationship. I don't think I have ever really talked to anybody about the way I managed my own clinical relationship. P9*

This trust provided honest responses to questions that add to the credibility of the data and findings.

This study confirms some previous findings as well as fills a gap in the literature with support and additional information to guide clinical practice with the transgender population.

### **Limitations.**

Phenomenological research does not provide data and conclusions that can be generalized to the larger population being studied. The sample was one of convenience and self-selection, therefore eliminating some breadth of experience. There were few

participants of racial diversity, again limiting the breadth of findings. It is unknown how the findings may have been impacted by some limitation of demographic diversity.

Two important factors in limitations of sampling, therefore results, are the cisgender identity of the researcher and the general distrust of the research and academic communities. These factors may have also been factors in self-selection for the study.

## **Conclusion**

This dissertation study was created to gain understanding of clinical relationships from the perspective of transsexual women who experienced them during their emergence into gender role transition. A phenomenological approach was chosen to give voice to those women who actually experience these clinical relationships, rather than merely making assumptions based on the perspectives of the clinicians who work with them. The participants reported sharing candid thoughts regarding their clinical experiences and offered suggestions to improve clinical relationships. The findings support previous studies that have explored the gate-keeping and power differential issues, as well as Lev's transgender emergence developmental stages theory. During analysis, the results were discovered to require context of prior experiences and assumptions on both the part of the client and the clinician. The essence of the experience was described as self-preservation driven by fear.

Implications for social work research, theory, practice and education were presented and discussed. There is little in the social work literature regarding work with this vulnerable population, therefore the recommendations encompass all aspects of the social work profession.

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## APPENDIX A: GLOSSARY

Excerpt from  
Gender Madness in American Psychiatry,  
Essays from the Struggle for Dignity  
by Kelley Winters, Ph.D.,  
2008, GID Reform Advocates  
[www.gendermadness.com](http://www.gendermadness.com)

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Labels, Titles and Terms ... “Oh my!”

The following list describes the most common terms I use to discuss issues of gender diversity and mental health policy. It is not comprehensive and does not imply a consensus within the trans-community on their use –far from it.

In social movements among marginalized people, there is often tension between those who strive to assimilate with the dominant culture, to blend in, and those who strive to change the dominant culture to extend dignity and equality to all. There is often tension between those who strive to build coalition and solidarity among the oppressed versus those who separate and distance themselves from others who are even more marginalized. Out of this tension, terms and labels of human diversity become the focus of passionate controversy and are subject to change without notice.

I strive to take responsibility for my own language, clarify the meaning I ascribe to my words, and learn from the feedback I receive from others. I have found that much misunderstanding stems from ambiguity between terms of social identity, human phenomena and psychiatric diagnosis. They are very different and serve different purposes. For terms of social identity, like transgender, my personal value is to err on the side of inclusion rather than exclusion. I do not intend to impose unwanted social identities on others, but nor do I wish to exclude people in our community who have suffered exclusion their whole lives. For terms of human phenomena, such as gender dysphoria, I feel that clarity is important. For diagnostic nomenclature, such as the derogatory title of Gender Identity Disorder, I believe the priority should be on harm reduction – to err on the side of limiting diagnosis to only those who would clearly benefit from diagnosis and meet scientific definitions of disorder. For terms of multiple contexts, such as transsexual (which may describe social identity, human phenomenon or psychiatric diagnosis), it is important to specify the intended meaning.

Affirmed {Son/Daughter/Boy/Girl/Man/Woman/Female/Male} –social identity.  
Acknowledging the gender identity of individuals (always termed with respect to the person’s expressed identity, not assigned birth sex.) Preferred by TransYouth Family Allies to describe youth.<sup>1</sup>

Anatomic Dysphoria –phenomenon. One type of gender dyphoria associated with persistent distress with current or anticipated (for preadolescent youth) physical sex characteristics that are incongruent with gender identity.

Cross-Dresser –social identity. People who wear clothing usually assigned to the opposite sex.<sup>2</sup> The term or its abbreviation CD are commonly associated with heterosexual males who identify primarily as male. Women in Western cultures less commonly identify as cross-dressers, since they are afforded more freedom of gender expression than men. The clinical term of mental disorder and sexual deviance, transvestite, is considered pejorative by many cross-dressers, though it remains a common term of social identity in Latin cultures.

FTM/MTF – phenomena. Shorthand for direction of social or medical transition: female-to-male and male-to-female, respectively. Generally, FTM refers to transmen and MTF to transwomen. However, these acronyms are controversial among those who feel they are too restricted to binary sex stereotypes and to some individuals, who prefer trans-to-male (TtoM) and trans-to-female (TtoF). On the other hand, this TtoM/TtoF notation is rejected by those who socially identify as both trans and male (or female), post-transition. Therefore, I use MTF and FTM only in the sense of the general direction of transition from a masculine or feminine birth-assignment to a space on the sex and gender spectra that differs from birth-assignment.

Gender –inclusive of multiple phenomena and social identities. A very broad multidimensional term that encompasses myriad combinations of human attributes that may be masculine, feminine, both or neither. Dimensions of gender include gender identity and gender expression, which may or may not correspond to each other or to social stereotypes of birth sex.

I also prefer to include physical sex and sexual orientation, each with its own broad spectrum of diversity, as dimensions of gender. This taxonomy reflects my view that humans are more than behavioral automata and illustrates the roles of the closet and social intolerance in suppressing gender diversity. It differs from that of Butler<sup>5</sup> and others who consider all aspects of sex, sexuality and gender subordinate to “gender performativity,” which resembles what I call gender expression.

Gender Dysphoria –phenomenon. Persistent distress with one’s current or anticipated physical sexual characteristics or current ascribed gender role.<sup>3</sup> It is defined more ambiguously in the DSM-IV-TR<sup>4</sup> and prior editions. The term was originally proposed as diagnostic nomenclature, “gender dysphoria syndrome,” by Fisk in the early 1970s.<sup>7</sup>

Since gender identity, arguably the most important component of gender, is not the actual subject of distress, gender dysphoria might be more accurately replaced by specific terms such as “anatomic dysphoria” and “gender role dysphoria.”

Gender Expression –phenomenon. The external social presentation of masculinity, femininity, both or neither, which may differ from biological sex or gender assigned at

birth or inner gender identity. In the case of a gender-variant person forced or shamed into the closet, gender expression may be opposite to gender identity.

Gender Identity –phenomenon. The internal sense of masculinity or femininity that a person experiences, not always congruent with biological sex or gender assigned at birth. Gender identity is who you are not who you like.<sup>1</sup>

I have observed that gender identity can be hidden or closeted but have not seen evidence that it can be coerced or changed. The adage by Virginia Prince that “Gender is between the ears,”<sup>6</sup> would describe what I call gender identity rather than gender.

Gender Reflex –phenomenon. The propensity of cultures, institutions and individuals to reduce all people to binary masculine and feminine gender stereotypes with associated presumptions of physical sex.

(Even trans-people are not immune to this habit; we just feel more guilty when we catch ourselves doing it.)

Gender Transcendence –phenomenon. Transcending the bounds of stereotypes associated with physical sex characteristics or assigned birth sex.

I prefer gender transcendence over transgender to describe the breadth of human gender diversity beyond binary stereotypes. See gender variance.

Gender Variance –phenomenon. Difference in gender identity or expression from stereotypes associated with physical sex characteristics or birth sex. Preferred by TransYouth Family Allies to describe gender diversity in children and youth for whom labels of social identity would be presumptuous.<sup>1</sup> See gender transcendence.

Maligning Language –phenomenon. Of the disrespectful language faced by gender-variant people, I feel that none is more damaging or hurtful than that which disregards our gender identities, denies affirmed social roles of those who have transitioned, and reduces us to our assigned birth sex. I am speaking of affirmed transwomen being called “he” and transmen being called “she.” I use the term Maligning Language to describe this specific kind of verbal violence and believe it is respectful to address people in the sense of their identified or expressed gender, which may differ from their assigned birth sex.

Sex –phenomenon. Physical sex, which is comprised of a number of attributes: anatomical, physiological, hormonal, reproductive, genetic, chromosomal, brain-sex and birth-assignment. Physical sex may align with gender identity and social gender expression or may differ in myriad ways. According to the Organisation Intersexués Internationales, one in 100 people are born with bodies differing from standard male or female phenotypes or genotypes.<sup>8</sup>

Transgender –social identity. An umbrella community term describing a wide diversity of people who differ in gender identity or gender expression from social expectations of assigned birth sex. This may include those who identify as transsexual, transitioned,

cross-dresser, bi or dual gender, genderqueer, gender nonconforming, and many other descriptions. Often abbreviated Trans, Transgender as an inclusive social identity is often conflated with transgenderist, a much narrower exclusive term coined by Virginia Prince in the 1970s to describe those who transition full-time in social role without a desire for surgical procedures.<sup>9</sup> She earlier used the term transgenderal in a similar context.<sup>10</sup> Transgender as an adjective with no suffix is commonly considered more respectful than transgendered or as a noun. Not all people in various categories of gender diversity socially identify as Transgender.

I prefer to use transgender in its most inclusive sense and as a term of social identity. I use gender transcendence or gender variance to describe phenomena of gender diversity.

Transsexual –social identity. A term describing a person whose inner gender identity is incongruent with her or his born physical sex characteristics. Many transsexual individuals seek medical treatments to bring their bodies into harmony with their gender identities, though not all are able or choose to do so. Transsexual, coined by psychiatrist Harry Benjamin in the 1960s,<sup>11</sup> is most respectfully used as an adjective. Although the term is often used to describe the phenomenon of sex/gender incongruence, not all people who have transitioned socially or medically identify as Transsexual. For example, Transsexualism is a label of mental disorder in the International Statistical Classification of Diseases and Related Health Problems (ICD)<sup>12</sup> and is considered pejorative by some people outside North America . Some post-operative people regard Transsexual identity as transitional and refer to it in the past tense. Some Transsexual individuals also identify with the broader transgender community; others do not.

Therefore, I prefer to use Transsexual as a term of social self-identity, which may include pre-operative, post-operative or non-operative individuals.

1 “Learning the Lingo,” TransYouth Family Allies, 2008, [http://imatyfa.org/permanent\\_files/learning-the-lingo-06-08.pdf](http://imatyfa.org/permanent_files/learning-the-lingo-06-08.pdf)

2 A. Lev, A. Lev, *Transgender Emergence, Therapeutic Guidelines for Working with Gender-Variant People and Their Families*, Haworth Press, 2004, p. 396.

3 Working definition of Gender dysphoria by Dr. Randall Ehrbar and I following our panel presentations at the 2007 convention of the American Psychological Association.

4 Defined in glossary of the DSM-IV-TR as “A persistent aversion toward some of all of those physical characteristics or social roles that connote one’s own biological sex.” (2000, p. 823)

5 J. Butler , *Gender Trouble: Feminism and the Subversion of Identity*, Routledge, 1989.

6 V. Prince, "Sex versus Gender," *Proceedings of the 2nd Interdisciplinary Symposium on Gender Dysphoria Syndrome*, Stanford , Calif. , 1973, pp. 20-24

7 N. Fisk, "Gender dysphoria syndrome. (The how, what, and why of a disease)," In D. Laub & P. Gandy (Eds.), *Proceedings of the second interdisciplinary symposium on gender dysphoria syndrome*, Stanford, 1973, pp. 7-14.

8 "How Common is Intersex? Prevalence of Variations," Organisation Intersexués Internationales, 2008,  
[http://www.intersexualite.org/how\\_common\\_is\\_intersex.pdf](http://www.intersexualite.org/how_common_is_intersex.pdf)

9 V. Prince, "The 'Transcendents' or 'Trans' People," *Transvestia*, v. 16, n. 95, pp. 81-92.

10 P. Bentler and C. Prince, "Personality Characteristics of Male Transvestites III," *Journal of Abnormal Psychology*, v. 72, n. 2, pp. 140-143.

11 H. Benjamin, *The Transsexual Phenomenon*, Julian Press, 1966, p. 23.

12 International Statistical Classification of Diseases and Related Health Problems (ICD), Version 10, 2007,  
<http://www.who.int/classifications/apps/icd/icd10online/?gf64.htm+f64>

## APPENDIX B: STANDARDS OF CARE

### **The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Version February, 2001**

Committee Members: Walter Meyer III M.D. (Chairperson), Walter O. Bockting Ph.D., Peggy Cohen-Kettenis Ph.D., Eli Coleman Ph.D., Domenico DiCeglie M.D., Holly Devor Ph.D., Louis Gooren M.D., Ph.D., J. Joris Hage M.D., Sheila Kirk M.D., Bram Kuiper Ph.D., Donald Laub M.D., Anne Lawrence M.D., Yvon Menard M.D., Stan Monstrey M.D., Jude Patton PA-C, Leah Schaefer Ed.D., Alice Webb D.H.S., Connie Christine Wheeler Ph.D.

This is the sixth version of the Standards of Care since the original 1979 document. Previous revisions were in 1980, 1981, 1990, and 1998.

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#### **I. Introductory Concepts**

##### **The Purpose of the Standards of Care.**

The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation.

#### **The Overarching Treatment Goal.**

The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

#### **The Standards of Care Are Clinical Guidelines.**

The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders. When eligibility 2 requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may modify them. Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol. These departures should be recognized as such, explained to the patient, and documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve.

### **The Clinical Threshold.**

A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person's development, become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity. The person's struggles are then variously informally referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, gender conflict, or transsexualism. Such struggles are known to occur from the preschool years to old age and have many alternate forms. These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity, and the perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures--the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)--they are formally designated as suffering from a gender identity disorder (GID). Some persons with GID exceed another threshold--they persistently possess a wish for surgical transformation of their bodies.

### **Two Primary Populations with GID Exist -- Biological Males and Biological Females.**

The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biologic, social, psychological, and economic dilemmas of each sex. All patients, however, should follow the SOC.



## **II. Epidemiological Considerations**

### **Prevalence.**

When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bona fide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates of prevalence for transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people, and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons' gender identity disorders fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists. 3

### **Natural History of Gender Identity Disorders.**

Ideally, prospective data about the natural history of gender identity struggles would inform all treatment decisions. These are lacking, except for the demonstration

that, without therapy, most boys and girls with gender identity disorders outgrow their wish to change sex and gender. After the diagnosis of GID is made the therapeutic approach usually includes three elements or phases (sometimes labeled triadic therapy): a real-life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics. Five less firmly scientifically established observations prevent clinicians from prescribing the triadic therapy based on diagnosis alone: 1) some carefully diagnosed persons spontaneously change their aspirations; 2) others make more comfortable accommodations to their gender identities without medical interventions; 3) others give up their wish to follow the triadic sequence during psychotherapy; 4) some gender identity clinics have an unexplained high drop out rate; and 5) the percentage of persons who are not benefited from the triadic therapy varies significantly from study to study. Many persons with GID will desire all three elements of triadic therapy. Typically, triadic therapy takes place in the order of hormones ==> real-life experience ==> surgery, or sometimes: real-life experience ==> hormones ==> surgery. For some biologic females, the preferred sequence may be hormones ==> breast surgery ==> real-life experience. However, the diagnosis of GID invites the consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy.

### **Cultural Differences in Gender Identity Variance throughout the World.**

Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country

to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.

### **III. Diagnostic Nomenclature**

#### **The Five Elements of Clinical Work.**

Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

#### **The Development of a Nomenclature.**

The term *transsexual* emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term *true transsexual*. The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and 4 adulthood; 2) minimal or no sexual arousal to cross-dressing; and 3) no heterosexual interest, relative to their anatomic sex. True transsexuals could be of

either sex. True transsexual males were distinguished from males who arrived at the desire to change sex and gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and that some of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of true transsexual females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender variant behaviors such as female cross-dressing remained unseen by clinicians. The term "gender dysphoria syndrome" was later adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature. The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

#### **The DSM-IV.**

In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with a strong and persistent crossgender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who

did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to females; attracted to both; or attracted to neither. This subclassification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was **not** intended to guide treatment decisions. Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner -- that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

#### **The ICD-10.**

the ICD-10 now provides five diagnoses for the gender identity disorders (F64):

**Transsexualism** (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

### **Dual-role Transvestism**

(F64.1) has three criteria:

1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
2. There is no sexual motivation for the cross-dressing;
3. The individual has no desire for a permanent change to the opposite sex.

### **Gender Identity Disorder of Childhood**

(64.2) has separate criteria for girls and for boys. For girls:

1. The individual shows persistent and intense distress about being a girl, and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages to being a boy) or insists that she is a boy;
2. Either of the following must be present:
  - a. Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing;
  - b. Persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
    1. An assertion that she has, or will grow, a penis;

2. Rejection of urination in a sitting position;
3. Assertion that she does not want to grow breasts or menstruate.
3. The girl has not yet reached puberty;
4. The disorder must have been present for at least 6 months.

For boys:

1. The individual shows persistent and intense distress about being a boy, and has a desire to be a girl, or, more rarely, insists that he is a girl.
2. Either of the following must be present:
  - a. Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games, and activities;
  - b. Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
    1. That he will grow up to become a woman (not merely in the role);
    2. That his penis or testes are disgusting or will disappear;
    3. That it would be better not to have a penis or testes.
3. The boy has not yet reached puberty;
4. The disorder must have been present for at least 6 months.

**Other Gender Identity Disorders (F64.8)** has no specific criteria.

### **Gender Identity Disorder, Unspecified**

has no specific criteria. 6 Either of the previous two diagnoses could be used for those with an intersexed condition. The purpose of the DSM-IV and ICD-10 is to guide

treatment and research. Different professional groups created these nomenclatures through consensus processes at different times. There is an expectation that the differences between the systems will be eliminated in the future. At this point, the specific diagnoses are based more on clinical reasoning than on scientific investigation.

### **Are Gender Identity Disorders Mental Disorders?**

To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person or cause personal mental suffering. The DSM-IV and ICD-10 have defined hundreds of mental disorders which vary in onset, duration, pathogenesis, functional disability, and treatability. The Designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments.

## **IV. The Mental Health Professional**

### **The Ten Tasks of the Mental Health Professional.**

Mental health professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

1. To accurately diagnose the individual's gender disorder;
2. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;



3. To counsel the individual about the range of treatment options and their implications;
4. To engage in psychotherapy;
5. To ascertain eligibility and readiness for hormone and surgical therapy;
6. To make formal recommendations to medical and surgical colleagues;
7. To document their patient's relevant history in a letter of recommendation;
8. To be a colleague on a team of professionals with an interest in the gender identity disorders;
9. To educate family members, employers, and institutions about gender identity disorders;
10. To be available for follow-up of previously seen gender patients.

#### **The Adult-Specialist.**

The education of the mental health professional who specializes in adult gender identity disorders rests upon basic general clinical competence in diagnosis and treatment of mental or emotional disorders. Clinical training may occur within any formally credentialing discipline -- for example, psychology, psychiatry, social work, counseling, or nursing. The following are the recommended minimal credentials for special competence with the gender identity disorders:

1. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have documented credentials from a proper training facility and a licensing board.

2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).

3. Documented supervised training and competence in psychotherapy.

4. Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.

### **The Child-Specialist.**

The professional who evaluates and offers therapy for a child or early adolescent with GID should have been trained in childhood and adolescent developmental psychopathology. The professional should be competent in diagnosing and treating the ordinary problems of children and adolescents. These requirements are in addition to the adult-specialist requirement.

### **The Differences between Eligibility and Readiness.**

The SOC provide recommendations for eligibility requirements for hormones and surgery. Without first meeting these recommended eligibility requirements, the patient and the therapist should not request hormones or surgery. An example of an eligibility requirement is: a person must live full time in the preferred gender for twelve months prior to genital surgery. To meet this criterion, the professional needs to document that the real-life experience has occurred for this duration. Meeting readiness criteria -- further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role -- is more complicated, because it rests upon the clinician's and the patient's judgment.

## **The Mental Health Professional's Relationship to the Prescribing Physician and Surgeon.**

Mental health professionals who recommend hormonal and surgical therapy share the legal and ethical responsibility for that decision with the physician who undertakes the treatment. Hormonal treatment can often alleviate anxiety and depression in people without the use of additional psychotropic medications. Some individuals, however, need psychotropic medication prior to, or concurrent with, taking hormones or having surgery. The mental health professional is expected to make this assessment, and see that the appropriate psychotropic medications are offered to the patient. The presence of psychiatric co-morbidities does not necessarily preclude hormonal or surgical treatment, but some diagnoses pose difficult treatment dilemmas and may delay or preclude the use of either treatment.

## **The Mental Health Professional's Documentation Letter for Hormone Therapy or Surgery**

### **Should Succinctly Specify:**

1. The patient's general identifying characteristics;
2. The initial and evolving gender, sexual, and other psychiatric diagnoses;
3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
4. The eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery;
5. The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;

6. Whether the author of the report is part of a gender team;

7. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document. The organization and completeness of these letters provide the hormone-prescribing physician and the surgeon an important degree of assurance that mental health professional is knowledgeable and competent concerning gender identity disorders.

**One Letter is Required for Instituting Hormone Therapy, or for Breast Surgery.**

One letter from a mental health professional, including the above seven points, written to the physician who will be responsible for the patient's medical treatment, is sufficient for instituting hormone therapy or for a referral for breast surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

**Two Letters are Generally Required for Genital Surgery.**

Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus. It is ideal if mental health professionals conduct their tasks and periodically report on these processes as part of a team of other mental health professionals and nonpsychiatric physicians. One letter to the physician performing genital surgery will generally suffice as long as two mental health professionals sign it. More commonly, however, letters of recommendation are from mental health professionals who work alone without colleagues experienced with gender identity disorders. Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are

required prior to initiating genital surgery. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient. Each letter, however, is expected to cover the same topics. At least one of the letters should be an extensive report. The second letter writer, having read the first letter, may choose to offer a briefer summary and an agreement with the recommendation.

## **V. Assessment and Treatment of Children and Adolescents**

### **Phenomenology.**

Gender identity disorders in children and adolescents are different from those seen in adults, in that a rapid and dramatic developmental process (physical, psychological and sexual) is involved. Gender identity disorders in children and adolescents are complex conditions. The young person may experience his or her phenotype sex as inconsistent with his or her own sense of gender identity. Intense distress is often experienced, particularly in adolescence, and there are frequently associated emotional and behavioral difficulties. There is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few gender variant youths become transsexual, although many eventually develop a homosexual orientation. Commonly seen features of gender identity conflicts in children and adolescents include a stated desire to be the other sex; cross dressing; play with games and toys usually associated with the gender with which the child identifies; avoidance of the clothing,

demeanor and play normally associated with the child's sex and gender of assignment; preference for playmates or friends of the sex and gender with which the child identifies; Phenomenologically, there is a qualitative difference between the way children and adolescents present their sex and gender predicaments, and the presentation of delusions or other psychotic symptoms. Delusional beliefs about their body or gender can occur in psychotic conditions but they can be distinguished from the phenomenon of a gender identity disorder. Gender identity disorders in childhood are not equivalent to those in adulthood and the former do not inevitably lead to the latter. The younger the child the less certain and perhaps more malleable the outcome.

### **Psychological and Social Interventions.**

The task of the child-specialist mental health professional is to provide assessment and treatment that broadly conforms to the following guidelines:

1. The professional should recognize and accept the gender identity problem. Acceptance and removal of secrecy can bring considerable relief.
2. The assessment should explore the nature and characteristics of the child's or adolescent's gender identity. A complete psychodiagnostic and psychiatric assessment should be performed. A complete assessment should include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child's environment are often present.
3. Therapy should focus on ameliorating any comorbid problems in the child's life, and on reducing distress the child experiences from his or her gender identity problem and other difficulties. The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with

his or her gender identity. This includes issues of whether to inform others of the child's situation, and how others in the child's life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety in relation to the child's gender expression and how best to manage it. Professional network meetings can be very useful in finding appropriate solutions to these problems.

### **Physical Interventions.**

Before any physical intervention is considered, extensive exploration of psychological, family and social issues should be undertaken. Physical interventions should be addressed in the context of adolescent development. Adolescents' gender identity development can rapidly and unexpectedly evolve. An adolescent shift toward gender conformity can occur primarily to please the family, and may not persist or reflect a permanent change in gender identity. Identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility; more fluidity may return at a later stage. For these reasons, irreversible physical interventions should be delayed as long as is clinically appropriate. Pressure for physical interventions because of an adolescent's level of distress can be great and in such circumstances a referral to a child and adolescent multi-disciplinary specialty service should be considered, in locations where these exist. Physical interventions fall into three categories or stages:

1. Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.

2. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
3. Irreversible interventions. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one state to another should not occur until there has been adequate time for the young person and his/her family to assimilate fully the effects of earlier interventions.

### **Fully Reversible Interventions.**

Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two. If for clinical reasons it is thought to be in the patient's interest to intervene earlier, this must be managed with pediatric endocrinological advice and more than one psychiatric opinion. Two goals justify this intervention: a) to gain time to further explore the gender identity and other developmental issues in psychotherapy; and b) to make passing easier if the adolescent continues to pursue sex and gender change. In order to provide puberty delaying hormones to an adolescent, the following criteria must be met:

1. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors;
2. sex and gender discomfort has significantly increased with the onset of puberty;
3. the family consents and participates in the therapy.



Biologic males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or antiandrogens (which block testosterone secretion or neutralize testosterone action). Biologic females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogens and progesterone) to stop menstruation.

### **Partially Reversible Interventions.**

Adolescents may be eligible to begin masculinizing or feminizing hormone therapy as early as age 16, preferably with parental consent. In many Countries 16-year olds are legal adults for medical decision making, and do not require parental consent. Mental health professional involvement is an eligibility requirement for triadic therapy during adolescence. For the implementation of the real-life experience or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months. While the number of sessions during this six-month period rests upon the clinician's judgment, the intent is that hormones and the real-life experience be thoughtfully and recurrently considered over time. In those patients who have already begun the real-life experience prior to being seen, the professional should work closely with them and their families with the thoughtful recurrent consideration of what is happening over time.

### **Irreversible Interventions.**

Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of 18 should be seen as an eligibility criterion and

not an indication in itself for active intervention.

## **VI. Psychotherapy with Adults**

### **Basic Observation.**

Many adults with gender identity disorder find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort.

**Psychotherapy is Not an Absolute Requirement for Triadic Therapy.** Not every adult gender patient requires psychotherapy in order to proceed with hormone therapy, the real-life experience, hormones, or surgery. Individual programs vary to the extent that they perceive a need for psychotherapy. When the mental health professional's initial assessment leads to a recommendation for psychotherapy, the clinician should specify the goals of treatment, and estimate its frequency and duration. There is no required minimum number of psychotherapy sessions prior to hormone therapy, the real-life experience, or surgery, for three reasons: 1) patients differ widely in their abilities to attain similar goals in a specified time; 2) a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth; 3) the mental health professional can be an important support to the patient throughout all phases of gender transition. Individual programs may set eligibility criteria to some minimum number of sessions or months of psychotherapy. The mental health professional who conducts the initial evaluation need not be the psychotherapist. If

members of a gender team do not do psychotherapy, the psychotherapist should be informed that a letter describing the patient's therapy might be requested so the patient can proceed with the next phase of treatment.

### **Goals of Psychotherapy.**

Psychotherapy often provides education about a range of options not previously seriously considered by the patient. It emphasizes the need to set realistic life goals for work and relationships, and it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.

### **The Therapeutic Relationship.**

The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issues with the patient during the initial diagnostic evaluation. Other issues may be better dealt with later, after the person feels that the clinician is interested in and understands their gender identity concerns. Ideally, the clinician's work is with the whole of the person's complexity. The goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. Even when these initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person's original sex assignment and previous gendered experience.

### **Processes of Psychotherapy.**

Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50-minutes sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity expression. Gender distress often intensifies relationship, work, and educational dilemmas. The therapist should make clear that it is the patient's right to choose among many options. The patient can experiment over time with alternative approaches. Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness, because the therapist and patient must cooperate in defining the patient's problems, and in assessing progress in dealing with them. Collaboration can prevent a stalemate between a therapist who seems needlessly withholding of a recommendation, and a patient who seems too profoundly distrusting to freely share thoughts, feelings, events, and relationships. Patients may benefit from psychotherapy at every stage of gender evolution. This includes the post-surgical period, when the anatomic obstacles to gender comfort have been removed, but the person may continue to feel a lack of genuine comfort and skill in living in the new gender role.

### **Options for Gender Adaptation.**

The activities and processes that are listed below have, in various combinations, helped people to find more personal comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.

Activities:

Biological Males:

1. Cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion;
2. Changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures;
3. Increasing grooming, wardrobe, and vocal expression skills.

Biological Females:

1. Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion;
2. Changing the body through breast binding, weight lifting, applying theatrical facial hair;
3. Padding underpants or wearing a penile prosthesis.

Both Genders:

1. Learning about transgender phenomena from: support groups and gender networks, communication with peers via the Internet, studying these Standards of Care, relevant lay and professional literatures about legal rights pertaining to work, relationships, and public cross-dressing;

2. Involvement in recreational activities of the desired gender;
3. Episodic cross-gender living.

Processes:

1. Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;
2. Acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression;
3. Integration of male and female gender awareness into daily living;
4. Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships.

## **VII. Requirements for Hormone Therapy for Adults**

### **Reasons for Hormone Therapy.**

Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.

### **Eligibility Criteria.**

The administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist.

1. Age 18 years;
2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
3. Either:
  - a. A documented real-life experience of at least three months prior to the administration of hormones; or
  - b. A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months). In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 – for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

### **Readiness Criteria.**

Three criteria exist:

1. The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
2. The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality);
3. The patient is likely to take hormones in a responsible manner.

### **Can Hormones Be Given To Those Who Do Not Want Surgery or a Real-life Experience?**

Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

### **Hormone Therapy and Medical Care for Incarcerated Persons.**

Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

### **VIII. Effects of Hormone Therapy in Adults**

The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and this cannot be



overcome by increasing dosage. The degree of effects actually attained varies from patient to patient.

**Desired Effects of Hormones.** Biologic males treated with estrogens can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment. Biologic females treated with testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

**Potential Negative Medical Side Effects.**

Patients with medical problems or otherwise at risk for cardiovascular disease may be more likely to experience serious or fatal consequences of cross-sex hormonal treatments. For example, cigarette smoking, obesity, advanced age, heart disease, hypertension, clotting abnormalities, malignancy, and some endocrine abnormalities may increase side effects and risks for hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician. Side effects in biologic males treated with estrogens and progestins may include increased propensity to blood clotting (venous thrombosis with a risk of fatal

pulmonary embolism), development of benign pituitary prolactinomas, infertility, weight gain, emotional lability, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus. Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability, increases in sexual desire, shift of lipid profiles to male patterns which increase the risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction.

### **The Prescribing Physician's Responsibilities.**

Hormones are to be prescribed by a physician, and should not be administered without adequate psychological and medical assessment before and during treatment. Patients who do not understand the eligibility and readiness requirements and who are unaware of the SOC should be informed of them. This may be a good indication for a referral to a mental health professional experienced with gender identity disorders. The physician providing hormonal treatment and medical monitoring need not be a specialist in endocrinology, but should become well-versed in the relevant medical and psychological aspects of treating persons with gender identity disorders. After a thorough medical history, physical examination, and laboratory examination, the physician should again review the likely effects and side effects of hormone treatment, including the potential for serious, life-threatening consequences. The patient must have the capacity to appreciate the risks and benefits of treatment, have his/her questions answered, and agree to medical monitoring of treatment. The medical record must contain a written informed consent document reflecting a discussion of the risks and benefits of hormone therapy. Physicians have a wide latitude in what hormone preparations they may prescribe and what routes of administration they may select for

individual patients. Viable options include oral, injectable, and transdermal delivery systems. The use of transdermal estrogen patches should be considered for males over 40 years of age or those with clotting abnormalities or a history of venous thrombosis. Transdermal testosterone is useful in females who do not want to take injections. In the absence of any other medical, surgical, or psychiatric conditions, basic medical monitoring should include: serial physical examinations relevant to treatment effects and side effects, vital sign measurements before and during treatment, weight measurements, and laboratory assessment. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

For those receiving estrogens, the minimum laboratory assessment should consist of a pretreatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pretreatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self examination. As they age, they should be monitored for prostatic cancer. For those receiving androgens, the minimum laboratory assessment should consist of pretreatment liver function tests and complete blood count with reassessment at 6 months, 12 months, and yearly thereafter. Yearly palpation of the liver should be considered. Females who have undergone mastectomies and who have a family history of breast cancer should be monitored for this disease. Physicians may provide their patients with a brief written statement indicating that the person is

under medical supervision, which includes cross-sex hormone therapy. During the early phases of hormone treatment, the patient may be encouraged to carry this statement at all times to help prevent difficulties with the police and other authorities.

### **Reductions in Hormone Doses After Gonadectomy.**

Estrogen doses in post-orchietomy patients can often be reduced by 1/3 to ½ and still maintain feminization. Reductions in testosterone doses post-oophorectomy should be considered, taking into account the risks of osteoporosis. Lifelong maintenance treatment is usually required in all gender patients.

### **The Misuse of Hormones.**

Some individuals obtain hormones without prescription from friends, family members, and pharmacies in other countries. Medically unmonitored hormone use can expose the person to greater medical risk. Persons taking medically monitored hormones have been known to take additional doses of illicitly obtained hormones without their physician's knowledge. Mental health professionals and prescribing physicians should make an effort to encourage compliance with recommended dosages, in order to limit morbidity. It is ethical for physicians to discontinue treatment of patients who do not comply with prescribed treatment regimens.

### **Other Potential Benefits of Hormones.**

Hormonal treatment, when medically tolerated, should precede any genital surgical interventions. Satisfaction with the hormone's effects consolidates the person's identity as a member of the preferred sex and gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. In biologic males, hormones alone often

generate adequate breast development, precluding the need for augmentation mammoplasty. Some patients who receive hormonal treatment will not desire genital or other surgical interventions.

### **The Use of Antiandrogens and Sequential Therapy.**

Antiandrogens can be used as adjunctive treatments in biologic males receiving estrogens, though they are not always necessary to achieve feminization. In some patients, antiandrogens may more profoundly suppress the production of testosterone, enabling a lower dose of estrogen to be used when adverse estrogen side effects are anticipated.

Feminization does not require sequential therapy. Attempts to mimic the menstrual cycle by prescribing interrupted estrogen therapy or substituting progesterone for estrogen during part of the month are not necessary to achieve feminization.

### **Informed Consent.**

Hormonal treatment should be provided only to those who are legally able to provide informed consent. This includes persons who have been declared by a court to be emancipated minors and incarcerated persons who are considered competent to participate in their medical decisions. For adolescents, informed consent needs to include the minor patient's assent and the written informed consent of a parent or legal guardian.

### **Reproductive Options.**

Informed consent implies that the patient understands that hormone administration limits fertility and that the removal of sexual organs prevents the capacity to reproduce. Cases are known of persons who have received hormone therapy and sex

reassignment surgery who later regretted their inability to parent genetically related children. The mental health professional recommending hormone therapy, and the physician prescribing such therapy, should discuss reproductive options with the patient prior to starting hormone therapy.

Biologic males, especially those who have not already reproduced, should be informed about sperm preservation options, and encouraged to consider banking sperm prior to hormone therapy. Biologic females do not presently have readily available options for gamete preservation, other than cryopreservation of fertilized embryos. However, they should be informed about reproductive issues, including this option. As other options become available, these should be presented.

## **IX. The Real-Life Experience**

The act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience. The real-life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. Since changing one's gender presentation has immediate profound personal and social consequences, the decision to do so should be preceded by an awareness of what the familial, vocational, interpersonal, educational, economic, and legal consequences are likely to be. Professionals have a responsibility to discuss these predictable consequences with their patients. Change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children. These represent external reality issues that must be confronted for success in the new gender presentation. These consequences may be quite

different from what the patient imagined prior to undertaking the real-life experiences.

However, not all changes are negative.

### **Parameters of the Real-Life Experience.**

When clinicians assess the quality of a person's real-life experience in the desired gender, the following abilities are reviewed:

1. To maintain full or part-time employment;
2. To function as a student;
3. To function in community-based volunteer activity;
4. To undertake some combination of items 1-3;
5. To acquire a (legal) gender-identity-appropriate first name;
6. To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

### **Real-Life Experience versus Real-Life Test.**

Although professionals may recommend living in the desired gender, the decision as to when and how to begin the real-life experience remains the person's responsibility. Some begin the real-life experience and decide that this often imagined life direction is not in their best interest. Professionals sometimes construe the real-life experience as the real-life test of the ultimate diagnosis. If patients prosper in the preferred gender, they are confirmed as "transsexual," but if they decided against continuing, they "must not have been." This reasoning is a confusion of the forces that enable successful adaptation with the presence of a gender identity disorder. The real-life experience tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the mental

health professional in their judgments about how to proceed. Diagnosis, although always open for reconsideration, precedes a recommendation for patients to embark on the real-life experience. When the patient is successful in the real-life experience, both the mental health professional and the patient gain confidence about undertaking further steps.

#### **Removal of Beard and other Unwanted Hair for the Male to Female Patient.**

Beard density Is not significantly slowed by cross-sex hormone administration. Facial hair removal via electrolysis is a generally safe, time-consuming process that often facilitates the real-life experience for biologic males. Side effects include discomfort during and immediately after the procedure and less frequently hypo-or hyper pigmentation, scarring, and folliculitis. Formal medical approval for hair removal is not necessary; electrolysis may be begun whenever the patient deems it prudent. It is usually recommended prior to commencing the real-life experience, because the beard must grow out to visible lengths to be removed. Many patients will require two years of regular treatments to effectively eradicate their facial hair. Hair removal by laser is a new alternative approach, but experience with it is limited.

### **X. Surgery**

#### **Sex Reassignment is Effective and Medically Indicated in Severe GID.**

In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any



meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.

### **How to Deal with Ethical Questions Concerning Sex Reassignment Surgery .**

Many persons, including some medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions, or alterations are made to body features to improve the patient's self image. Among those who object to sex reassignment surgery, these conditions are not thought to present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients discuss their life histories and dilemmas. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder. It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.

### **The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental**

#### **Health Professional.**

The surgeon is not merely a technician hired to perform a procedure. The

surgeon is part of the team of clinicians participating in a long-term treatment process. The patient often feels an immense positive regard for the surgeon, which ideally will enable longterm follow-up care. Because of his or her responsibility to the patient, the surgeon must understand the diagnosis that has led to the recommendation for genital surgery. Surgeons should have a chance to speak at length with their patients to satisfy themselves that the patient is likely to benefit from the procedures. Ideally, the surgeon should have a close working relationship with the other professionals who have been actively involved in the patient's psychological and medical care. This is best accomplished by belonging to an interdisciplinary team of professionals who specialize in gender identity disorders. Such gender teams do not exist everywhere, however. At the very least, the surgeon needs to be assured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with gender identity disorders. This is often reflected in the quality of the documentation letters. Since fictitious and falsified letters have occasionally been presented, surgeons should personally communicate with at least one of the mental health professionals to verify the authenticity of their letters.

Prior to performing any surgical procedures, the surgeon should have all medical conditions appropriately monitored and the effects of the hormonal treatment upon the liver and other organ systems investigated. This can be done alone or in conjunction with medical colleagues. Since pre-existing conditions may complicate genital reconstructive surgeries, surgeons must also be competent in urological diagnosis. The medical record should contain written informed consent for the particular surgery to be performed.

## **XI. Breast Surgery**

Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. Although breast appearance is definitely important as a secondary sex characteristic, breast size or presence are not involved in the legal definitions of sex and gender and are not important for reproduction. The performance of breast operations should be considered with the same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body.

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Female-to-male patients may have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

## **XII. Genital Surgery**

### **Eligibility Criteria.**

These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical

contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");

3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;

4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;

5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;

6. Awareness of different competent surgeons.

#### **Readiness Criteria.**

The readiness criteria include:

1. Demonstrable progress in consolidating one's gender identity;
2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

#### **Can Surgery Be Provided Without Hormones and the Real-life Experience?**

Individuals cannot receive genital surgery without meeting the eligibility criteria. Genital surgery is a treatment for a diagnosed gender identity disorder, and should undertaken only after careful evaluation. Genital surgery is not a right that must be granted upon

request. The SOC provide for an individual approach for every patient; but this does not mean that the general guidelines, which specify treatment consisting of diagnostic evaluation, possible psychotherapy, hormones, and real-life experience, can be ignored. However, if a person has lived convincingly as a member of the preferred gender for a long period of time and is assessed to be a psychologically healthy after a requisite period of psychotherapy, there is no inherent reason that he or she must take hormones prior to genital surgery.

### **Conditions under which Surgery May Occur.**

Genital surgical treatments for persons with a diagnosis of gender identity disorder are not merely another set of elective procedures. Typical elective procedures only involve a private mutually consenting contract between a patient and a surgeon. Genital surgeries for individuals diagnosed as having GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

### **Requirements for the Surgeon Performing Genital Reconstruction.**

The surgeon should be a urologist, gynecologist, plastic surgeon or general surgeon, and Board-Certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even

experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers. Surgeons should attend professional meetings where new techniques are presented. Ideally, the surgeon should be knowledgeable about more than one of the surgical techniques for genital reconstruction so that he or she, in consultation with the patient, will be able to choose the ideal technique for the individual patient. When surgeons are skilled in a single technique, they should so inform their patients and refer those who do not want or are unsuitable for this procedure to another surgeon.

#### **Genital Surgery for the Male-to-Female Patient.**

Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

#### **Other Surgery for the Male-to-Female Patient.**

Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals. There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

### **Genital Surgery for the Female-to-Male Patient.**

Genital surgical procedures may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, the patient should be clearly informed that there are several separate stages of surgery and frequent technical difficulties which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one surgery. The plethora of techniques for penis construction indicates that further technical development is necessary.

### **Other Surgery for the Female-to-Male Patient.**

Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.

## **XIII. Post-Transition Follow-up**

Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery. Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable, local, long-term aftercare in the

patient's geographic region. Postoperative patients may also sometimes exclude themselves from follow-up with the physician prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any postoperative adjustment difficulties.



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# EX-GI BECOMES BLONDE BEAUTY

## *Operations Transform Bronx Youth*

Story on Page 3



### A World of a Difference

George W. Jorgensen Jr., son of a Bronx carpenter, served in the Army [▲] for two years and was given honorable discharge in 1946. Now George is no more. After six operations, Jorgensen's sex has been changed and today she is a striking woman [←], working as a photographer in Denmark. Parents were informed of the big change in a letter Christine (that's her new name) sent to them recently.

—Story on page 3

# Ex-GI Becomes Blonde Beauty

## Bronx Youth Is a Happy Woman After 2 Years, 6 Operations

By BEN WHITE

(Copyright 1952 by News Syndicate Co., Inc.)

A Bronx youth, who served two years in the Army during the war and was honorably discharged, has been transformed by the wizardry of medical



(NEWS photo, Copyright 1952 by News Syndicate Co., Inc.)

George-Christine says of this photo: "It looks too much like a clothes model, but it really is, for I am so proud of my handiwork—made jacket and skirt and gloves."



George-Christine as a girl.



(NEWS photo, Copyright 1952 by News Syndicate Co., Inc.)

George-Christine as a boy.

science into a happy, beautiful young woman, The News learned yesterday.

Subject of the rare sex-conversion is the former George W. Jorgensen Jr., son of a Bronx carpenter, whose name and all past Army records have been officially changed to Christine Jorgensen. The new woman has made a successful career for herself as a color photographer in Denmark and hopes some day to go to Hollywood, either as a photographer or an actress.

It was through a rare and complicated treatment that George became Christine. The conversion—rare when a woman becomes a man, much rarer when a man changes into woman—involved five major operations, a minor operation and almost 2,000 injections which worked both physiological and glandular revolutions in George-Christine's body.

The story of George-Christine was told yesterday by the father, George, a Board of Education carpenter, and his wife, Florence, at

their home 2847 Dudley Ave., Bronx.

Not till last June, after the protracted treatment had been successfully completed, did the Jorgensens know that their son had even contemplated the radical sex change.

Then, in a long letter which enclosed photographs of the new Christine, now a 26-year-old blonde, they learned what had been happening at the Riche Hospital, Copenhagen, under the world-famed Prof. Hamburger.

"Several small unimportant-looking glands and yet our whole body is governed by them," the letter said.

And, again: "It is more a problem of social taboos and the desire not to speak of the subject because it deals with the great hush hush, namely sex."

**Fear'd Harm to Mind.**

Then there was a line: "You see, I was afraid for a much more horrible illness of the mind." Further on, still without quite breaking the news, the letter said, "Right from the beginning, I realized that I was working toward the release of myself from a life I knew would always be foreign to me."

And then the shock: "Just how does a child tell its parents such a story as this? I am still the same old Brud (nick-

name), but, my dear, nature made a mistake which I have had corrected and now I am your daughter."

And, finally, the strange, wistful ending:

"I do so want you to like me very much and not to be hurt because I did not tell you sooner about why I came over here."

"Love,

"Chris

"Brud"

Thunderstruck, the Jorgensens held family council with their only other child, a daughter, who is married and has a baby of her own.

**Father Informs Friends.**

Then, they said, they decided that their lifelong friends, fellow members of the Danish Young Society, which meets regularly at Askow Hall in Throggs Neck, the Bronx, should hear the news.

Jorgensen called a meeting of 22 of his closest friends at a neighbor's home and told them. All of them—who remembered George as a quiet youngster who preferred reading to sports—agreed that the right thing had been done.

Yesterday the elder Jorgensen explained that his former son had been drafted into the Army in 1944, had served two years at Fort Dix and then received his honorable discharge.

Immediately afterward, he enrolled in the New York Medical Technicians Institute here for 16 months—and only after receiving the letter of last June, did the parents realize why.

The then-George was studying the glands which had played tricks

(Continued on page 10, col. 5)

## Letter Informing Parents

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Here is the text of the sensitive and affectionate letter in which George Jorgensen Jr. told his parents that his sex had been changed and that he was now their daughter it read:

My Dearest Mom, Dad:

I am now faced with the problem of writing a letter, one which for two years has been in my mind. The task is a great one and the two years of thought haven't made the task any easier.

To begin with, I want you to know that I am healthier and happier than ever. I want you to keep this in mind during the rest of this letter.

I suppose I should begin with a little philosophy about life and we, the complex people who live that life, life is a strange affair and seems to be stranger as we experience more of it. It is often that we think of the individuality of

each person, and yet we are all basically the same.

### Seeking the Why When Something Goes Wrong

Nevertheless, we are different, looks, temperament and then nature often for some unknown reason steps in and adds her peculiarities. Complex about various things and physical deformities.

Those things are all a part of life—but we do not accept them and strive through science to answer the great question of "Why?" "Why did it happen," where did something go wrong and, last but not least, what can we do to prevent it and cure it if it has already happened.

At times it is obvious something

has gone wrong but in many other cases it is not obvious and only shows up in small ways. This leads to investigation and, if necessary, medical aid.

### Imbalance in Glandular System Cleared Up

We humans are perhaps the greatest chemical reaction in the world and therefore it is not strange that we are subject to so very many physical ailments. Among the greatest working parts of our bodies are the glands. Several small unimportant looking glands, yet our whole body is governed by them.

An imbalance in the glandular

(Continued on page 10, col. 3)

### NEWS ON THE AIR

TELEVISION—WPIX—Channel 11

3 & 4 p. m.—News

6:30 p. m.—Teleplay

7:00 p. m.—News at Seven

10:30 p. m.—Teleplay

10:50 p. m.—Tomorrow's News

12:30 a. m.—Sundown News

RADIO—WNEW—Dial 1130

"News Around the Clock"—at half past every hour.



## Aldrich to Be New Envoy to Great Britain

(Continued from page 2)

cial reorganization committee are Dr. Arthur S. Flemming, president of Ohio Wesleyan, and Dr. Milton Eisenhower, president of Penn State College, and a brother of Ike.

### Long Conference

This committee together with Dr. Robert L. Johnson, president of Temple University and chairman of the citizens committee for the Hoover reorganization plan, conferred several hours yesterday, starting at 10:30 A. M., at 60 Morningside Drive. Also present was Bernard L. Gladieux of Scarsdale, who is associated with the Ford Foundation. He will be a committee adviser.

Eisenhower's office released an exchange of letters with Dr. Johnson, who made available the reorganization studies of a Temple University research group. Ike asked the committee to review those portions of the Hoover Commission plan of 1948 for government reorganization still unacted upon.

Aldrich, the new Ambassador to Britain, long has been closely iden-



(NEWS photo by Tom Watson) Arthur H. Vandenberg Jr. leaves the Eisenhower residence.

tified with the Republican Party. He had a part in inducing Governor Dewey to run for a third term. Aldrich went to the Chicago convention this year to back Ike.

### Son of a Senator

The banker is the son of the late Senator Nelson W. Aldrich of Rhode Island, long a power in the Republican Party. His sister, the late Abby Aldrich Rockefeller, was the first wife of John D. Rockefeller Jr. and the mother of their daughter and five sons. The Aldriches have four daughters and a son.

Aldrich became chairman of Chase, known in Wall Street as "the Rockefeller bank," in the turbulent financial days of January, 1933. He shocked Wall Street with some banking reform proposals and was a frequent caller at the White House in the early days of President Roosevelt.

He is a director of American Telephone and Telegraph Co. and several other big businesses. He is a yachting enthusiast and a former commodore of the New York Yacht Club. He was a member of the syndicate that built the yacht Enterprise, which beat Sir Thomas Lipton's Shamrock V in four America's cup races.

The Aldrich appointment must be confirmed by the Senate.

### Clay on Calling List

Nelson Rockefeller, 44, is president and chairman of the board of Rockefeller Center. He is a son of John D. Rockefeller Jr. He served the Roosevelt Administration in Latin American affairs and was an Assistant Secretary of State in 1943 and 1948.

The calling list for 60 Morningside Drive today includes John

## When Physician Changed Her Sex



After he officially became a man.

The most recent widely-known case of sex change was announced in England when Dr. Elizabeth Forbes-Sempill of Kildrummy, Scotland, who had practiced medicine as a woman for



Dr. Ewan Forbes-Sempill before change.

20 years, started her noble family by announcing she had become a man. To underscore the point Dr. Forbes-Sempill, who took the name of Ewan, married his housekeeper. In the case of

the doctor, the change was gradual over a period of years. The diminution of the female sexual characteristics and assertion of the male tendencies was finally completed by an operation.

## Letter Tells Parents Of Son's Sex Change

(Continued from page 3)

system puts the body under a strain in an effort to adjust that imbalance. This strain, although not usually fatal, has a great effect on our well-being both physically and mentally.

I, along with millions of other people, had such a system imbalance. I use the past tense "had" because the condition has been cleared. Although a long, very slow process, Dr. Hamburger has completely cleared it up. He is a great man and a most brilliant scientist.

### Months of Tests And Examinations

Mine was not a too usual case although the condition is not so rare as the average person would think. It is more a problem of social taboos and the desire not to speak of the subject, because it deals with the great hush-hush, namely sex.

It was for this reason that I came to Europe and primarily to Dr. Hamburger, because, upon investigation, I had found him to be one of the greatest gland and hormone specialists in the world.

Dr. Hamburger was very willing to undertake my case because he doesn't have the chance very often of securing a patient who could give such complete cooperation as I could. This cooperation meant months of daily tests and examinations.

### Why Should We Be Shocked or Surprised?

I do not know if you know that both men and women have hormones of both sexes in their bodies. Regardless of many outward appearances, it is the quantity of these hormones which determine a person's sex. All sex characteristics, etc., are a result of these hormones.

Sometimes a child is born and to all outward appearances seems to be of a certain sex. During childhood nothing is noticed, but at the time of puberty, where the sex hormones come into action the chemistry of the body seems to take an odd turn and chemically the child is not of the supposed sex, but rather of the other sex.

This may sound rather fantastic and unbelievable, but I think Dr. Hamburger's words fit it to a tee. He said to me: "The body and life itself is the world's strangest

thing. Why, then, should we be shocked or even surprised by anything this strange mechanism does?" And how true those words are.

### "Working for Release Of Myself"

I was one of those people I have just written about. It was not an easy fact to face but only for the happiness it brought me I should not have had the strength to go through these two years. You see, I was afraid of a much more horrible illness of the mind. One which, although very common, is not as yet accepted as a true illness with the necessity for great understanding.

Right from the beginning I realized that I was working toward the release of myself from a life I knew would always be foreign to me. So you see, the task was not so difficult, not nearly so much so as this letter for me is to write.

Just how does a child tell the parents such a story as this? And even as I write these words, I have not yet told you the final outcome of the tests and an operation last September. I do hope that I have built this letter properly, so you already know what I am going to say now—

### "And Now I Am Your Daughter."

I have changed, changed very much, as my photos will show, but I want you to know that I am extremely happy and that the real me, not the physical me, has not changed. I am still the same old Brud, but, my dear, nature made the mistake which I have had corrected and now I am your daughter.

I do so want you to like me very much and not to be hurt because I did not tell you sooner about why I came over here. I felt, and still do, that it was the right way to do it. It wasn't because I didn't want you to be in on it, but rather it would have done no good for you to spend all this time worrying when I was in no danger whatsoever.

### Stands By Decision, Right or Wrong.

I knew that you must be told and it would have been easier on me if I had told you earlier, but I just knew it to be best this way. Right or wrong, it was my decision

and I still stand by it. Please don't be hurt.

Tania Tine (Aunt Tine) can tell you more, for we have had some good talks. She paid me the biggest compliment when she said, "My goodness, you look like both Dolly and Dorothy."

I can't write more now. I seem to be all dried up for this time.

Waiting at every post delivery for your letter...

Love, Chris, Brud.

## Ex-GI Turned Into a Woman By Sex Expert

(Continued from page 3)

on him and, he thought, were driving him toward madness.

After the institute, George went to California. There he met two persons who were to have the most remarkable effect on his life.

One was a Dr. Kauffman, who recognized his problem, was sympathetic and told him that marvelous work on sex conversion was being done at the Serum Institute in Copenhagen.

The other was Mrs. Ellen Thompson, who owns a farm in Denmark and, though not a physician, was equally sympathetic to the social-psychological dilemma of George.

About three years ago, George returned with her to Denmark, George explaining to his parents that he wanted to stop color photography, in which he already had won several prizes.

After a period of traveling on the Continent, the ex-GI visited Dr. Hamburger at the Serum Institute, and the sex expert explained some of the mysteries of the glands, and some of the medical-social problems that George faced.

He also told George that in the U. S., there were probably 10,000 other persons similarly afflicted.

Putting himself completely in the hands of the conversationalist, George underwent the long, long treatment, both in the Serum Institute and at Riga Hospital. His letter to his parents emphasized that he was never in danger at any time.

So far as the parents were concerned, there was no cost, except for occasional funds to keep George in pocket money. The priceless treatments were performed free by Dr. Hamburger.

Dr. Eugene Andersen, U.S. Ambassador to Denmark, was fully aware of what was going on and at the successful conclusion of the operations, arranged that Christine's records be changed by the Army and the Veterans Administration—and also by the Bureau of Immigration so that the man who went abroad three years ago could be readmitted as a woman.

Discovered Miss Denmark. Since the treatments, Christine has been working happily and successfully as a woman color photographer. She has sold pictures to Danish magazines and newspapers and, one day, while shopping, discovered Hanne Sorensen the attractive miss who later became Miss Denmark in a world-wide beauty contest.

While she's happy in Denmark, she plans at an unannounced date to come home and pursue a career in the U. S.

(Other pictures on page 1)

## Gets Hand Caught In Elevator Door

Raymond Vann, 36, of 19 W. 56th St., a building watchman, was trapped more than an hour in a near-deserted office building at 29 W. 57th St. yesterday when his hand became wedged in an elevator door on the eighth floor. He was freed by police summoned by a tenant who heard Vann's cries. He was taken to Roosevelt Hospital.

## Tommies Return

Southampton, England, Nov. 30 (AP)—The 1st Battalion of the Middlesex Regiment, first English unit to serve in Korea, returned today after 3½ years' overseas duty.

## APPENDIX D: PARTICIPANT INFORMED CONSENT

### **Understanding the experience of male-to-female transsexuals in a clinical relationship**

You are invited to participate in a study that seeks to gain understanding of the experience of being a transgender person in therapy initiated to obtain medical treatment. This is a dissertation study that involves research using qualitative methods. The research method being used for this study includes interviews with individuals such as yourself who identify as a male-to-female transsexual person who has completed the gender role and sex reassignment process. The interview will be audio recorded with your consent, to ensure accuracy of reporting your responses to questions.

During the interview, you will be asked questions regarding your values, thoughts, feelings, and experiences surrounding your experience as a transsexual person in clinical work to obtain approval for transgender medical intervention. The interview will take about one and a half hours with the possibility of a follow up phone call or interview appointment. You may discontinue the interview at any time if you find yourself becoming uncomfortable.

Your name will not be used in the research report and your confidentiality will be protected by a number of procedures. Pseudonyms will be used in the research report in order to protect your identity. The demographic survey will remain in a private, locked file cabinet in the office of the researcher and only viewed by the researcher and the supervising professor. The audio recordings will be coded without your name on them and kept in the same file cabinet with the survey on separate discs. The audio recordings will only be heard by the researcher, the supervising professor, and the transcriptionist. Each of these professionals are informed and trained in the codes of confidentiality. There are two exceptions to the promise of confidentiality. If information is revealed concerning suicide, homicide, or child abuse and neglect, it is required by law that this be reported to the proper authorities. In addition, should any information contained in this study by the subject of a court order or lawful subpoena, the University of Denver might not be able to avoid compliance with the order or subpoena.

This study is being conducted as part of a doctoral research dissertation. The results of this study may be published in various forms at a later date, but your name will never be published.

There is minimal risk to you by your participation in this study. Your confidentiality is protected in this process, but the interview experience may create some anxiety for you. Sometimes when subjects talk about experiences that hold emotional value for them, they might feel some strong emotions during and after the interview process. The researcher will debrief with you regarding any strong emotional reactions to the interview process. Referrals for supportive services will also be available if needed.

If you have any concerns or complaints about how you were treated during the interview, please contact Susan Sadler, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-3454, or Sylk Sotto-Santiago, Office of Research and Sponsored Programs at 303-871-4052 or write to either at the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121. This dissertation research is being supervised by Dr. Susan Manning of the University of Denver Graduate School of Social Work. You may contact her if needed at 303-871-2865.

The benefit to you as a participant of this study is the opportunity to tell your story. By participating in this study, you will be making a positive contribution to the growing body of research in this emerging field of study.

You are free to withdraw your consent and discontinue participation at any time without prejudice from the researcher. You are encouraged to ask any questions you may have at any time and to inform the researcher of any discomfort related to the research procedures. Again, confidentiality will be maintained at all times, with the above exceptions, and your identity as a participant will not be disclosed without your consent.

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I have read and understood the foregoing descriptions of this research study. I have asked for and received a satisfactory explanation of any language that I did not fully understand. I agree to participate in this study, and I understand that I may withdraw my consent at any time.

I have received a copy of this consent form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

☐ I agree to be audiotaped.

☐ I do not agree to be audiotaped.

Signature \_\_\_\_\_ Date \_\_\_\_\_

☐ I would like a summary of the results of this study to be mailed to me at the following e-mail address: \_\_\_\_\_

## APPENDIX E: INTERVIEW GUIDE

### **Introduction:**

Thanks for participation – will add to growing body of knowledge

My credentials, experience

My expectations of study interview – honesty from participant  
I will be non-judgmental

You do not have to answer any questions you don't want to;  
you may stop at any time

Ask for clarification of anything you don't understand

Term definitions/preferred terms:  
SRS/GRS

HRT

Your gender identity before transition, during, after (now)

How long ago did you complete your transition?

How long was your transition process?

### **Main Question:**

Tell me about your experience of therapy to accomplish transition.

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Do you know of the Standards of Care?

Describe your understanding of the Standards of Care.

Describe the ways in which your therapist followed the standards of care.

How do you feel about the Standards of Care?

Do you know and understand the term “gate-keeping?”

How do you feel about this term?

At what point in the transition process did you engage with a therapist?

What prompted that contact?

How many therapists did you see during your transition process?

How many did you contact before your first session?

Did you reject any and why?

Why did you choose the one you saw?

Did you speak to anyone to get a referral?

What were your thoughts and feelings before making your first appointment?

In what way did this change after contacting the therapist to schedule your first appointment?

Tell me about your first appointment.

How often did you see your therapist? For how long?

Tell me about non-prescription hormones.

How was the decision made that you were ready to start hormones under a doctor's supervision?

How long did you see your therapist after obtaining your HRT letter?

How did you obtain your SRS letter? Second letter?

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**Conclusion:**

Is there anything else you'd like to tell me that we didn't get to?

Do you have any questions of me?

Thank you very much for your participation in this important research! Your willingness to share your experiences makes an important contribution to this area of study.